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influence of the liability reform variables on loss ratio is accompanied by a comparable pattern of influence on loss levels. In contrast, premiums seem only modestly affected by the liability reform measures, so that the main mechanism has been to reduce the losses associated with policies as opposed to raising the price that can be charged." Viscusi and Born (Journal of Legal Studies: 1995, p 496) also state that "liability reform not only enhances profitability but also diminishes uncertainty by having its greatest effect" on the must unprofitable insurers. The AMA also found that professional liability insurance (PLI) premium increases are driven in large part by verdict awards and settlement costs and that the relative frequency of very large awards is increasing.[48] The report found that manual PLI rates for California, which caps damages, are less than half those in the largest states that do not have effect tort reform. The AMA offers three policy options: the most promising tort reform proposals may be those that focus on elements such as award caps; policy initiatives to stabilize supply, finances and operations of carriers may offer a more productive approach to mitigating PLI crises; and that local initiatives must take into account the local drivers of premium increases that predominate within individual jurisdictions.[49]

Hunter and Doroshow, in discussing the impact of tort reforms on medical malpractice insurance rates from 1985-1998, argue that tort law limits enacted since the liability insurance crisis of the mid-1980s have not lowered insurance rates in the ensuing years.[50] The authors also argue that states with little or no tort law restrictions have experienced

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[48] Ibid, p.7
[49] American Medical Association. "Medical Professional Liability Insurance." Health Care Financial Trends Report. Chicago: American Medical Association, April 2002.
[50] Hunter, J. Robert, and Joanne Doroshow. Premium Deceit: The Failure of 'Tort Reform' to Cut Insurance Prices. New York: Center for Justice and Democracy, 2002.

 

the same level of insurance rates as those states that enacted severe restrictions on victims' rights.[51] In their analysis of tort reform impacts on medical malpractice rates, Hunter and Doroshow argue the existence of an "apparent difference between levels of tort law change and overall rate/loss cost impact."[52] Hunter and Doroshow (2002, p. 16) state "the underlying costs, which ultimately drive insurance prices, are impacted upwardly by mid-range medical malpractice tort law changes..." Hunter and Doroshow argue that "one reasonable conclusion is that no clear evidence of tort law change impacting insurance prices is determinable" from the data that was analyzed.[53] Zuckerman, Bovbjerg and Sloan found that "other than imposing caps or reducing the time available to initiate claims, tort reforms are not observed individually to lower premium."[54]

Another goal of tort reform measures are to reduce budgetary costs to health care providers. Danzon (Handbook of Health Economics, Volume 1: 2000, p 1371) argues that the outcome such reforms "is likely to result, at best, in simply shifting costs from medical providers to patients and taxpayers; at worst, total social costs may actually increase if, for example, deterrence incentives are weakened." Thorton (Applied Economics, 1999, pg 215) found that "tort signal effects appear to prompt primary care physicians to work longer hours in an effort to devote more time and attention to patients..." which "...may well reduce the incidence of negligence and increase the quality of care. Evidence from simulations also suggests that the impact of these

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[51] Ibid. p. 2
[52] Ibid. p. 16
[53] Ibid. p. 17
[54] Zuckerman, Stephen, Randall R. Bovbjerg, and Frank Sloan. "Effects of Tort Reforms and Other Factors on Medical Malpractice Insurance Premiums." Inquiry 27 (Summer 1990): p. 180.

 

defensive actions on utilization and fee, at the margin, may be relatively minor." Kessler and McClellan (NBER Working Paper No. 6346: 1998) found that their analysis results "suggest that reforms in law affect physicians' attitudes, both by reducing the probability of an encounter with the liability system and by changing the nature of the experience of being sued, for those physicians who defend against malpractice claims."

States have tried a variety of legislative changes to control medical malpractice insurance costs. Several of these are identified and discussed in the following subsections.

Several researchers have studied the impact of tort reforms enacted following prior medical liability crises. In 1986, the GAO performed a case study of six states (Arkansas, California, Florida, Indiana, New York and North Carolina) that had enacted tort reform measures following the crisis in the 1970s.[55] The study involved surveys of organizations representing physicians, hospitals, insurers and lawyers.[56] The study found that in two states, those groups surveyed believed that tort reforms had helped to moderate upward trends in the cost of insurance as well as the average amount paid per claim.[57] Those surveyed in the other four states felt that tort reforms had little effect in their states.

In a report to the Senate on the impact of tort reforms on medical malpractice frequency and severity following the medical malpractice crisis of the 1970s, Danzon reported that three studied reviewed suggest that caps on awards and collateral source offset had significantly reduced claims severity and that collateral source offset and shorter statute

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[55] United States. General Accounting Office. Medical Malpractice: Six State Case Studies Show Claims and Insurance Costs Still Rise Despite Reforms. Washington, DC: GPO, 1986.
[56] Ibid. p. 2
[57] Ibid. p. 2

of repose have significantly reduced claim frequency.[58] Danzon also reported that arbitration statutes appeared to increase claims frequency and reduce average severity, while reforms including screening panels and limits on contingency fees appeared to have no systemic impact on claims frequency and severity.[59]

Viscusi et al. researched the impact of tort reforms following the 1980s medical liability crisis and found that insurance regulation variables had little apparent effect on medical liability insurance prices (Journal of Risk and Uncertainty 180). The study also found that while reforms modifying joint and several liability, limits on liability, limits on non-economic damages and limits on punitive damages did not constrain costs or enhance profitability, the reforms appeared to dampen changes in premium.

Viscusi and Born found that liability reforms on average, and in particular the damage cap provisions, contributed to a downward shift in the loss ratios, which implies a rise in the profitability of insurers.[60] They note that the effect is not uniform across all insurers, but that insurers that had been the least profitable benefited the most from reforms.[61] They also discovered that liability reforms were more influential on reducing losses and less so on increasing premiums.[62] The authors conclude that medical malpractice reform

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[58] Danzon, Patricia M. The Effects of Tort Reforms on the Frequency and Severity of Medical Malpractice Claims: A Summary of Research Results. U.S. Senate Committee on the Judiciary. Washington, DC, March 26, 1986. p. 9.

[59] Ibid.

[60] Viscusi, W. Kip and Patricia Born. "Medical Malpractice Insurance in the Wake of Liability Reform." Journal of Legal Studies 24 (1995): p. 490

[61] Ibid.

[62] Ibid.

 

consequently generated a variety of diverse effects that one would expect from a sound reform agenda.[63]

## Damage Limitations, Caps

Payments made to individuals to compensate for damages because of medical error are generally divided in two categories. First are economic damages. Economic damages usually consist of past and future medical expenses to provide care and rehabilitation and lost wages or earnings potential. These damages are measured in monetary terms, often using objective or third party standards such as wage receipts, medical bills, or expert estimates of degree of disability. The second major category is that of non-economic damages. Non-economic damages are not readily measurable and are subjective in nature. They consist of payments for such intangible damages as past and future pain and suffering, loss of consortium, mental anguish and in some cases, punitive damages.

**Table 35** lists states that have enacted damage limitations. A few states enacted statutory limitations on total damages but much less frequently than limitations on non-economic damages. It is important to note that when evaluating a total damage limitation, one must be aware of how it is applied. For example, while Indiana's $1,250,000 is a cap on all damages regardless of cause or source, the $500,000 cap in Louisiana is for non-medical damages only. Further, there are other areas of tort law that affect the settlement outcome such as whether the cap applies on a per occurrence basis for each health care provider or health care institution individually or collectively.

[63] Ibid. p. 491

 

A more common approach is for states to limit non-economic damages that an injured party can receive. There are many who believe that the limitation on non-economic damages is the most effective single reform that a state can enact. It should be noted this contention is still the subject of debate. Doctors, hospitals and insurers tend to favor such limitations, while the plaintiffs' bar and many consumer advocates are opposed.

Studying the effect of non-economic damage limitations is very difficult, as there does not appear to be reliable data to base an effective evaluation. First, courts do not routinely require that judgments distinguish between economic and non-economic damages when a judge or jury decides a case. Further, if a settlement is negotiated out of court, the insurer and the parties to the agreement are not inclined to separate the economic and non-economic aspects of the settlement. It is safe to say that enacting a non-economic damages limitation will have an impact on settlements or adjudicated claims with award values that reach levels exceeding the threshold of limitation. For most states, there is ample evidence that juries have awarded significant amounts; however, evaluating actual cost savings requires analysis on data that does not exist. At best a rudimentary estimate could be performed.

Damage caps or limitations provide insurers and the marketplace with information about the maximum dollar amount of loss any one insurance claim can be awarded, generally for noneconomic damages. When insuring a physician, insurers will assess the probability that he/she will have a claim filed against them and estimate how much the claim will cost the insurer. Without caps, insurers are forced to estimate what courts will,

 

in the future, award a plaintiff in a medical liability case. Recent years have seen large variations in the amounts of damages awarded in some cases, making such predictions difficult and inaccurate. The implementation of caps allows insurers to more accurately predict its costs arising from a claim and adds some stability to insurance prices in the market.

Caps on damages have two major impacts on individuals who potentially have a medical malpractice claim. First, total caps, that is caps on economic, noneconomic and punitive damages, may not make enough money for medical care necessary to reverse damages caused by medical mistakes or for any ongoing or life-long treatments the injured party may need. Some argue that noneconomic caps, in some cases, may be insufficient to appropriately compensate a victim for the intangible effects of the injury that has occurred. Secondly, caps may create a case of adverse selection when it comes to pursuing a claim. Since the costs of researching and arguing a medical malpractice case can be very large, awards available once caps are introduced may not, in some cases, cover even the costs associated with pursuing a claim.

Caps on noneconomic damages have been researched more than any of the tort reforms reviewed in this report. Danzon (Handbook of Health Economics, Volume 1: 2000) found that "caps directly constrain only a small percentage of cases, because roughly five percent of cases account for 50 percent of dollars paid." Danzon (ibid.) goes on to say that limits "are unlikely to undermine deterrence, because very high awards are typically not used for rating individuals (as opposed to class) liability premiums, being viewed as random bad luck." The Employment Policy Foundation (2003) argues, "states without

 

effective ceilings on non-economic damages experienced increases in medical malpractice premiums 3.7 times greater than states with ceilings." The Government Accounting Office (Medical Malpractice Insurance, 2003, p 43) found that, because of data limitations, "it is not possible to quantify the impact of a cap on noneconomic damages on insurers' losses. Similarly, it is not possible to show exactly how much a cap would affect claim frequency or claims-handling costs." Viscusi, et al (Inquiry: 1990, p 176), found that noneconomic caps had statistically significant effects on premium, frequency or severity.[64] Weiss (Medical Malpractice Caps: 2003) found that while caps on noneconomic damages did reduce insurer payout on claims, insurers continued to increase premiums, leading to the conclusion that more important factors such as medical inflation, the insurance business cycle, insufficient reserves, declining investment income, financial safety and supply and demand, drove the rise in medical malpractice premiums. Viscusi, et al (Journal of Risk and Uncertainty: 1993, p181) found that for the liability reform variables (specifically modified joint an several liability, limits on liability, noneconomic damages, or punitive damages, or other reforms) examined showed "no statistically significant effects appear on losses... Only one measure, limits on noneconomic damages, significantly depresses losses, resulting in a 14.7% decrease in 1985 loss levels." Ross (30 Ind. L Rev. 594), examining whether a state's independent interpretation of its equal protection laws should be considered when damage caps have been implemented, argues that caps "arbitrarily discriminate against those most severely injured. Furthermore, they are unlikely to effectuate their intended purpose of lowering malpractice insurance premiums and health care costs." Yoon (3 Amer. Law &

[64] The authors found that noneconomic damages were a significant at a 10% level of confidence when measured in the frequency and severity model.

 

Economics Review 199) found that "the average relative recovery by Alabama plaintiffs decreased by roughly $20,000 after the Alabama legislature enacted [total] damage caps and increased roughly double that amount after the Alabama Supreme Court ruled them unconstitutional." Sloan and Hoerger (4 Journal of Risk and Uncertainty 419) found that "more serious injuries were relatively undercompensated, and plaintiff who incurred high losses in cases in which defendants appeared to be innocent of wrongdoing were paid no more than those in which plaintiffs incurred a relatively minor loss. This undercuts the rationale for ceilings on payments for noneconomic loss or total loss." In an analysis of the effect of tort reforms on premiums stemming from the 1970s crisis, Zuckerman et al. found that; only reforms imposing a cap on the amount of physician liability or reducing the amount of time a plaintiff has to initiate a claim significantly lowered medical malpractice premiums; premium are lower in states that require prior approval of rates; and not as strong a link between the determinants of premiums, claims and awards as was expected.[65]

## Collateral Source Rules

Collateral source rules are provisions that allow or require the introduction of evidence concerning the plaintiff's recovery of medical and disability expenses from "collateral sources" such as health insurance, workers' compensation, Social Security, auto insurance medical payments or no-fault coverage and disability insurance. This allows a jury to consider the other sources of compensation available to a plaintiff before setting an award amount. Some states also allow or require consideration of compensation

[65] Zuckerman, Stephen, Randall R. Bovbjerg, and Frank Sloan. "Effects of Tort Reforms and Other Factors on Medical Malpractice Insurance Premiums." Inquiry 27 (Summer 1990): 167-182. p. 167/

 

received from multiple defendants as a collateral source of recovery. A number of other states, however, still observe the common-law collateral source rule that obligates a tortfeasor to pay the full amount of a plaintiff's damages without regard to whether other sources mitigated those losses. In these states, tort awards are not offset by compensation amounts received from other sources.

Collateral source rules recognize that double recovery for all or part of a plaintiff's damages unnecessarily adds to the expense of medical malpractice insurance. Changes to collateral source rules would be considered an effective tort reform if the changes provide just compensation while eliminating duplicative expenses. Limiting subrogation rights would provide that collateral benefit providers do not seek to recover the monies they contributed to the settlement. However, most health and disability policies have provisions stating that the policyholder must refund policy benefit payments to the insurer that that they also collect through the tort system. This theoretically would eliminate most double recovery situations. Under this situation, the issue of double recovery is eliminated. The issue then becomes whether the source of the payments to the plaintiff are made appropriately, i.e. whether the plaintiff should pay for a portion of the damages or whether the defendant is responsible for all of the damages.

The Secretary's Commission on Medical Malpractice recommended 1973 that an in-depth analysis be made to identify the cost of overlapping health insurance benefits and to identify methods of using resources to assure more complete coverage to all.[66] Danzon

[66] United States. Department of Health, Education, and Welfare. Medical Malpractice: Report of the Secretary's Commission on Medical Malpractice. Washington, DC: GPO, 1973.

 

(Handbook of Health Economics, Volume 1: 2000) argues that "collateral sources offset undermines deterrence by shifting costs from the tort defendant to other insurance programs and by reducing the plaintiff's incentive to bring a claim because of the lower expected award." Danzon (Journal of Law and Economics: 1984, Law and Contemporary Problems: 1986) found empirically that "collateral source offset rules have not only reduced claim severity but also claim frequency, consistent with the prediction that lower awards reduce the incentive to file." Viscusi, et al (Inquiry: 1990, p 176), found that neither permissible nor mandatory collateral offset had statistically significant effects on premium, frequency or severity.[67]

## Periodic Payment of Future Damages

Traditionally, medical liability insurers have paid tort settlements as one lump-sum settlement equal to the expected value of future losses. Periodic settlements allow for tort settlements to be paid over a course of many years, typically the expected lifetime of the plaintiff. Currently, several states mandate periodic payments, where several others provide an option to do so, either by request of the parties involved or the courts depending on the state statute requirements. Periodic payments are typically funded by annuities purchased from insurance companies. These annuitized payment arrangements are known to most as structured settlements.

A medical malpractice insurer can benefit by spreading the payments out over a longer period. An unused portion may be returned to the funding insurer. An insurer could also

[67] The authors found that mandatory collateral offset was a significant at a 10% level of confidence when measured in the frequency and severity model.

purchase an annuity where the present value of the future stream of payments is much less that a lump sum indemnity of the damages. Periodic settlements thus allow insurers to more accurately predict its loss expenses, which in turn allows them to set more consistent insurance rates for insureds. Periodic settlements may also be advantageous to the claimant because it guarantees a fund stream that will not be dissipated and will be available for future needs of the claimant. On the other side of the coin, it can be argued that periodic settlements take away the claimant's right to be compensated fairly because the claimant may not outlive the term of the periodic payments, which would preclude the claimant from being 'made whole'. In the event that an insurer becomes insolvent and has periodic payments settlement obligations it cannot meet, the cost of that obligation then shifts to either the state guaranty fund or, in the event the insurer is not covered by such a fund, to the claimant in terms of lost payments.

Henderson (32 Ariz. L. Rev. 76), argues that a "well designed periodic-installment judgment plan offers a number of opportunities to make significant improvements in the way tort victims are compensated."

## Legislative Strategy Regarding Bad Faith

Although every state's tort system is different, a common thread for insurers is the issue of bad faith. Insurers can be held liable for amounts that are in excess of the policy limit if the policyholder asks the insurer to settle with a claimant and the insurer proceeds to take the case to court and loses. Bad faith claims occur when the judgment against the policyholder exceeds the policy limit and the insurer foregoes the opportunity to settle at the policy limit or less. At the extreme, bad faith claims have the potential to be larger

 

than an insurer's surplus.

Perhaps more than any other element the insurance industry maintains that the bad faith provisions of law, currently found in many insurance codes, are subject to abuse by those representing people allegedly injured due to malpractice. Although the evidence is generally anecdotal, the insurance industry is united in its assertion that no medical malpractice reform would be effective without changing the ease with which bad faith allegations can be made. On the other hand, those representing victims allege that insurers were prone to play games with records, witnesses, and availability to delay legal proceedings. Interestingly, insurers also make the same allegations relative to victims and their representatives. Those representing victims also expressed concern that the financial strength of insurers could allow them to "wait-out" a victim for purposes of an inequitable settlement. The working group believes that those considering medical liability reform should evaluate possible changes to the laws regarding bad faith claims. The appendix contains a summary of changes recently made to Florida law related to bad faith claims.

Sykes (25 Journal of Legal Studies 443) concludes that "the courts seem to find tortuous conduct on the part of insurers who have bona fide disputes with their policyholders over the terms of the policy or over factual issues essential to the insured's right to recover. The ability of the courts to identify opportunistic behavior in such cases is very much in doubt, and the distinct possibility arises that bad faith doctrine here does little to police misconduct while doing much to cause uneconomic increases in the premiums that policyholders must pay."

 

## Alternative Dispute Resolution & Mediation

There are many ways to resolve disputes between two parties. The traditional method for medical liability claims is for the courts to hear from both sides and have either a judge or a jury decide what damages, if any, should be awarded. At the other end of the spectrum, is a settlement offer. This is a very informal process where the insurer, with the health care provider's permission, makes an offer to the plaintiff to settle the case before a trial becomes necessary. There are other methods that fall somewhere between these two extremes. Taking advantage of them offers opportunities to save time and expenses that are associated with a full trial in a court of law.

Some argue that one of the significant cost drivers of medical liability insurance is the sympathy factor. In cases where there is an adverse medical outcome that is not the result of a medical error, it can be argued that a compassionate jury would like to find a way to compensate those who have experienced a bad medical outcome and tend to sympathize with the plight of the victim. Care must be taken to strike a balance between the interests of the health care providers and those that have been victims of true medical malpractice. Establishing a balanced pre-trail screening process offers the potential to save both parties expense dollars by sorting out those cases that are likely to lead to an award from those that are simply unfortunate medical outcomes.

Further, expert witness reforms may contain costs if high standards are maintained. One option may be to use medical experts to certify the validity of the claimant's case so that

 

non-meritorious claims are eliminated before they reach a court. This process may also aid in settlement discussion, as many facts will come to light early in the process so that an offer of settlement can be tendered on cases with merit before going to trial.

Typically, loss adjustment expenses are higher for medical liability insurance than for other liability lines of insurance. This offers the potential for some savings if efforts to constrain costs are successful. Possible loss adjustment controls include the use of mediation or other alternative dispute resolution processes. Mediation or arbitration can be a successful loss adjustment control strategy. A state could consider adopting mediation or arbitration standards that treat all parties fairly. This would begin with a disclosure designed to alert the patient that he is agreeing to arbitration in lieu of a jury trial if that is the case. The disclosure must be clear and concise and should be agreed to by all parties. Arbitration can be either binding or non-binding and these conditions must be disclosed in advance. Rules regarding arbitration should consider whether the parties each have appropriate bargaining strength and whether they can bind others to the arbitration result in the case of joint and several liability. It should be noted that if there is discord surrounding an arbitrated dispute and either party can take the case once arbitrated to court, it is possible that arbitration might create an added layer of bureaucracy and actually add to expenses rather than diminish them.

In 1973, the Secretary's Commission on Medical Malpractice recommended that persons other than attorneys and members of the profession involved in the disputes be included as members of any mediation board or panel.[68] Danzon (Handbook of Health Economics,

[68] United States. Department of Health, Education, and Welfare. Medical Malpractice: Report of the Secretary's Commission on Medical Malpractice. Washington, DC: GPO, 1973.

 

Volume 1: 2000) agues that "theory and evidence indicate that mandatory screening, without significant penalties for appeal and without the panel's findings being admissible evidence in court, may simply add an additional tier of delay and costs." Danzon (Handbook of Health Economics, Volume 1: 2000) also argues that an "early binding offer system, combined with the English rule [the side that wins a suit is entitled to recover its expenses], creates incentives for each part to act on their true information, whereas bluff and strategic manipulation are penalized. By contrast, screening and mediation, without significant penalties for strategic post-screening behavior, simply increase delay and costs." The *authors* (Impact of Legal Reforms on Malpractice Costs, p72-3) note that the reluctance to use alternative dispute resolution programs "when it is not mandatory, coupled with questions about its constitutionality when mandatory, suggests that binding alternative dispute resolution (ADR) is unlikely to have much of an impact on direct malpractice costs." Viscusi, et al (Inquiry: 1990, p 176), found that allowing arbitration agreements did not have a statistically significant effect on premium, frequency or severity. Nelson (10 Am. Journ Trial Advoc. 362) questions whether "statutorily mandated mediation panels achieve any useful purpose. These panels may merely add another costly level to an already expensive and cumbersome litigation process. On the other hand, legislative attempts to encourage settlement, such as H.R. 3084, may provide benefits to both health care consumers and providers." Farber and White (23 Journal of Legal Studies 805) conclude, "patients involved in cases initiated through incident reports are less litigious ("more peaceful") than patients who initiated cases on their own either through a complaint or a lawsuit." Farber and White (23 Journal of Legal Studies 805) found that cases "initiated by patients through the complaint

process are not resolved (dropped, settled, tried to a verdict) significantly different from cases initiated by lawsuits, controlling for observable case characteristics." Farber and White (23 Journal of Legal Studies 806) suggest that "the complaint process is a cost-effective "front-end" for the litigation process that provides information to patients regarding the quality of their medical care and, hence, the likelihood of negligence." Vidmar And Rice (78 Iowa L Rev. 897) examined the results of several jury and mediated court decisions and found "no support to the widely held view that jurors are more generous than judges or arbitrators in awarding noneconomic damages. Moreover, the data do not support the view that the reasoning of laypersons calculating the award is substantially different from that of legally trained persons." Stevens (50 Dispute Resolution Journal 65) argues that the "potential contributions of ADR in various dispute-management settings depend in important part on how its adjudication function fits in as an integral part of the larger alternative dispute management system with which it is associated. Arbitration of these disputes would greatly facilitate adopting contract (rather than tort) as the legal basis for claims. In turn, contract – coupled with grievance procedures and arbitration – would provide a superior dispute management system for malpractice disputes in HMOs."

## Contingency Fee Limitation

Perhaps the most controversial reform involves limitations on attorney contingency fees. The lawyers for the plaintiff in medical liability cases are generally compensated on a contingency fee basis. In lieu of an hourly charge for services rendered, the attorney agrees to accept a percentage of the damage award if the lawsuit is successful. These

 

contingency fee arrangements can be as high as 50% of the award.

The arguments for contingency fee limitation are that it delivers more of the award to the person who sustained the injury and thus is fairer to victims of malpractice. Further, it helps weed out non-meritorious claims as attorneys are less inclined to take a chance on a doubtful recovery if their stake in the claim would be less. There are some who oppose contingency fee limitations. They argue that these limitations deny innocent victims their day in court as plaintiff's attorneys would be less inclined to take on cases with small potential dollar values regardless of its validity. Further, they say that it is unfair to attorneys to limit their earnings potential. While there are states that have implemented restrictions on the use of contingency fees, limiting the income of plaintiff attorneys is often a tough battle in a state legislature. California is an example of a state that has successfully implemented contingency fee limitations for medical liability insurance

Danzon (Handbook of Health Economics, Volume 1: 2000) found that "theoretical analysis predicts that the number of claims filed would be higher with a contingent fee, but appropriately so, because risk aversion would deter many plaintiffs from filing valid claims with an hourly fee." Danzon (Handbook of Health Economics, Volume 1: 2000) also found that the "objective of limits on contingent fees is unclear and effects of such limits on claims frequency and disposition... are uncertain." Danzon (Bell Journal of Economics: 2001) found that "given certain assumptions about the nature of competition, the contingent fee system induces the amount of attorney effort that would be chosen by a fully-informed, risk-neutral plaintiff who was paying an attorney by the hour." Danzon (Bell Journal of Economics: 2001) also states that if the "benchmark of optimal

 

expenditures on litigation is that which would be chosen by fully informed, risk-neutral plaintiffs, then regulation or prohibition of contingent fees will, if effective, result in suboptimal investment in pursuing claims." The Employment Policy Foundation (2003) argues, "if a claim is dropped before any cash settlement is offered, the plaintiff's lawyer gets nothing. The result is an increasingly prolonged and costly process of discovery that consumes physician's time, distracts them from patient care and raises the effort and cost of claims adjusters and defense attorneys on behalf of malpractice insurers." Viscusi, et al (Inquiry: 1990, p 176), found that attorney fee controls did not have a statistically significant effect on premium, frequency or severity. Public Citizen (Medical Misdiagnosis: 2003, p 22) argues that non-frivolous lawsuits are not common because of the costs associated with pursuing a medical malpractice case. Public Citizen (Medical Misdiagnosis: 2003, p 24) found in a review of several studies that there is a "consistent relationship between the severity of the injury and the size of the verdict. Uniformly the authors concluded that their findings did not support the contention that jury verdicts are frequently unpredictable and irrational." Spagnoli (19 Loyola Los Angeles L Rev 683) notes that while California courts have ruled that regulation on attorney's fees affect first amendment rights, "the court failed to conclusively establish that recognition of such rights would prevent regulation of all attorney fees." McMullen (1990 Journal of Dispute Resolution 384) states that "the effort to employ mediation as a method to resolve medical malpractice disputes" is hampered by the attorney's "standard philosophical map, the perceived economic threat, the lack of confidentiality laws, the lawyers' general lack of education in mediation, and the perception that mediation does not enforce social norms as well as the court system." Reames (62 Chi. Kent L. Rev. 271) argues,

 

"limitations on attorney fees proscribed by section 6146 [of the California Business and Professional Code] seriously abridge first amendment rights. By limiting contingency fees, the statute limits the number of qualified attorneys willing to petition on behalf of medical malpractice victims. Without a qualified attorney, a malpractice victim's right to petition for redress is a nullity."

## Other Legislative Measures

There are several other measures that state legislatures might consider to help with the medical liability situation.

## Special Courts

Kozak (19 Seton Hall Legis. J. 647) argues that "it is necessary for reform to focus on streamlining the [litigation] process by eliminating unnecessary or duplicative discovery, restricting the time to claims resolution, and screening claims before they have on opportunity to clog the court system."

The establishment of special courts dedicated to hearing medical liability disputes offers an opportunity for improvement. A jury is often not well positioned to make an informed decision about whether a medical error has occurred or to decide on an appropriate level of compensation. Further, judges who only occasionally hear a medical liability case are in no better position to make an informed decision than are juries. A remedy for that deficiency is the creation of special courts that are designed to hear medical liability cases exclusively. The judges in these special courts will, over time, gain a familiarity with

 

medical jargon and will have comparative experience from a variety of medical liability cases to serve as a common basis for evaluation of medical liability disputes. While this is not an immediate solution to a current crisis, over time establishment of a special court should prove beneficial.

### Advance Notice of Claims

Another potential legislative remedy is the introduction of a requirement that the plaintiff provide advanced notice of a claim. A claimant could be required to given defendants advance notice of intent to file a suit. A time period should be specified. A 90-day period should be sufficient. During the advance time period, both sides are expected to perform due diligence regarding the potential claim. There are many who believe that this advance notice period would often result in settlement of meritorious cases. Further it provides attorneys from both sides an opportunity to meet and exchange documents that will help them resolve the matter.

### *Other Reforms*

Poythress, Weiner and Schumacher (16 Law & Psych Rev 111) argue the "tort system's current punishment model should be revised in favor of an information-feedback model that clearly identifies the specific behaviors to be changed as the result of the finding of negligence. Fines for compensatory and/or punitive purposes will be much more effective in a framework in which the behaviors sanctioned are announced with sufficient precision that the defendant doctor and other members of the relevant profession can identify those practices that are unacceptable."

 

## Patient Compensation Funds

One reform adopted in some states is the use of patient compensation funds (PCF). **Table 36** lists states that have enacted PCFs. States with PCFs cap health care provider claims at a specified monetary level. Further redress is available to injured parties through a PCF for amounts above the monetary cap. PCFs generally limit the dollar amount they will provide in compensation. Except for its cap, a PCF by itself does not necessarily alter a state's tort system.

Patient Compensation Funds offer certainty to health care providers and their insurers by establishing a limit on the magnitude of losses a health care provider must bear. The cap on loss severity adds predictability to pricing medical liability insurance coverage. If frequency does not rise, medical liability premiums should remain relatively stable. The challenge involved with establishing a PCF revolves around funding. The debate generally is whether funding should come from private or public sources. There are those who believe that PFCs are not a good solution, as they do not change the claiming dynamics.

In 1973, the Secretary's Commission on Medical Malpractice recommended federal funding for one or more demonstration projects in order to test and evaluate the feasibility of possible alternative medical injury compensation systems as well as a federal feasibility study of establishing a patient injury insurance program, similar to

 

workers' compensation insurance, to provide designated compensation benefits for injuries arising from health-care, whether caused by medical malpractice or not.[69]

## Statutory Risk Sharing Mechanisms

State legislatures are often called to address availability and affordability of essential insurance products when the private sector fails to provide adequate coverage at prices acceptable to those paying the premium. It is generally the preference of state governments to allow the private sector to provide insurance coverage if it is willing to do so. Auto, property and workers' compensation insurance are the three most widely known examples of essential insurance coverage. Auto and workers' compensation are compulsory in most states. Property insurance is necessary for an economy to function, as financial institutions will not lend money if a person or business cannot secure the financial institution's interest through property insurance.

Medical liability insurance may be considered an essential insurance coverage as a medical care provider can lose hospital-attending privileges if insurance is unavailable. Thus, the health care system relies on the availability of affordable medical liability insurance. When coverage is unavailable or believed to be too expensive, medical care providers may consider limiting their practice, changing to a lower risk specialty, retiring or moving to another state with more favorable medical liability rates.

When the legislature senses that medical liability coverage is either unavailable or

[69] United States. Department of Health, Education, and Welfare. Medical Malpractice: Report of the Secretary's Commission on Medical Malpractice. Washington, DC: GPO, 1973.

 

unaffordable, one of the measures developed to remedy the situation is a risk-sharing mechanism. These are often residual market mechanisms that serve as a market of last resort. A common risk-sharing mechanism is the Joint Underwriting Association or JUA. A JUA typically is a risk sharing mechanism where the state either authorizes or requires one or more servicing carriers to issue medical liability policies to health care providers that are unable to obtain insurance from the voluntary market insurers. The premiums and losses associated with providing coverage through the JUA are shared by an association of the entire admitted market, or a significant portion of it. This is done through either assessment or a less common distribution of excess funds. The servicing carrier issues the policy, settles claims and provides other customary policyholder services. For that service, the servicing carrier is compensated at a fixed rate. A JUA is an effective means to provide coverage availability. JUA establishment by itself does not address the price or affordability of the insurance product. A JUA's insureds are usually those rejected by the voluntary market and may trend toward higher claims costs.

JUAs are valuable to a market because it provides a mechanism in which anyone that needs to obtain insurance coverage can do so. Insurance coverage from JUAs is typically more expensive than coverage in the traditional insurance market; hence these entities are used when there are availability issues in the market. JUAs have limited benefits in markets where affordability of existing coverage is the most pressing problem.

## Alternative Treatment of Trauma Centers and High Risk Specialties

Access to essential health care is becoming an issue in some states for certain high-risk specialties. There is a much higher incidence of medical liability claims observed in

certain specialties. Included in the high-risk specialties are delivery of newborns by obstetricians, performing brain surgery by neurosurgeons and treatment of trauma cases. The high cost of medical liability insurance can drive health care providers from these needed skill areas. This is particularly true for trauma centers, as the health care providers in these centers do not have the same continuing doctor-patient relationship as one would have with their primary care physician.

One of the potential legislative remedies that a state might consider is developing a different tort framework for these high-risk areas. One way to implement a tort framework would be to cap losses for these high-risk specialties at a specified amount and provide a patient compensation fund for the amount in excess of the cap. Taxpayers, health care providers or the insurance industry could finance the fund. Such a framework could provide certainty in pricing since the maximum possible loss is known in advance, leaving only a frequency component as a variable. However, as with any tort reform measure, there is always a question about whether limiting a claimant's right to full compensation through the tort system is a fair and equitable public policy goal.

## Patient Safety Measures & Data Reporting Issues

The American Medical Association (AMA) supports a change to the existing culture of blame and punishment to one where patient safety is paramount. The current tort system does not encourage health care providers to report and evaluate health care errors. Rather, it discourages health care providers from sharing information for fear that the information could someday be used against them in a lawsuit. This culture means that mistakes in

 

practice are not disclosed and others that could benefit and avoid repeating the error are not made aware that anything has occurred.

Some argue that one should replace such a system where health care providers are encouraged to report medical errors to a central source without fear of retribution. This would allow medical experts to evaluate alternative treatment parameters and disseminate information to the medical profession to avoid the occurrence of similar mistakes in the future. This is the model for the federal Aviation Safety Risk Analysis Program, which has successfully reduced aviation accidents in the U.S. since 1958. However, some argue that such information should be made available to the legal systems because the tort system is designed to prevent future reoccurrences of medical malpractice.

In 1973, the Secretary's Commission on Medical Malpractice recommended that insurers: develop sophisticated loss-prevention programs based on both injury and claims prevention techniques; specifically identify and allocate a portion of the premium dollar for institutional medical malpractice insurance towards loss-prevention; and provide analyses of incidents to institutional health-care providers in order to aid the institutions' injury protection programs.[70] The Commission also found that the unavailability of medical records without resort to litigation created needless expense and increases the incidence of unnecessary malpractice litigation.[71] It further recommended that States enact legislation-enabling patients to obtain access to information contained in their medical records through their legal representatives, public or private, without having to

[70] United States. Department of Health, Education, and Welfare. Medical Malpractice: Report of the Secretary's Commission on Medical Malpractice. Washington, DC: GPO, 1973.
[71] Ibid. p. 75

 

file a suit.[72]

Chaing (18 Yale J. on Reg. 408) argues that the most important aspects of implementing a reporting system are "assuring reporters [of data] that incident reports will not be used against them in litigation and removing non-legal disincentives, such as access and cultural barriers, to reporting." McClean (26 S. Ill. U. L. J. 227) argues "based on scientifically-derived clinical guidelines and mandatory reporting of adverse events for error analysis, risk managed care medicine will severely limit the autonomy of physicians. For medical malpractice attorneys, scientifically-derived clinical guidelines will create a presumptive standard of care, which, because of detailed statistical analysis, will be difficult to rebuke."

## Regulation of Investments

The high-risk investment strategies of some insurers and the casualties that occurred when the junk bond and real estate markets declined in the early 1990s have led regulators to reconsider their oversight of insurers' investments. Historically, state laws regulating insurers' investments were relaxed over the years to allow insurers to take advantage of high-yield investments to support new products. The NAIC, in 1990, adopted a model law restricting an insurer to no more than 20 percent of its admitted assets in non-investment grade bonds, with additional restrictions on the proportions of assets in the lower-rated categories. Several states adopted the model law or similar restrictions on junk bonds. This was accompanied by the refinement and strengthening of

[72] Ibid. p. 77

 

the process for assigning SVO credit designations or categorization of insurers' bonds and preferred stock.

In 1996, the NAIC adopted a comprehensive model law covering all insurer investments. The stated objectives of the model investment law are to: preserve principal; assure reasonable diversification; and require insurers to allocate investments prudently to meet obligations to insured and maintain sufficient financial strength to cover reasonably foreseeable contingencies. In general, the model law sets certain limits on the amounts or relative proportions of different assets that insurers can hold to ensure adequate diversification and limit risk.

Controversy about the investment model law led the NAIC to adopt a second investment model law that utilizes what is known as the "prudent person" approach. Conceptually, this approach allows insurers greater discretion in terms of their allocation of investments if they can demonstrate that they have a sound investment plan and that they adhere to that plan. Regulators are authorized to intervene if an insurer fails to meet this more general requirement.

Insurance companies are required to maintain records and file annual and quarterly financial statements with regulators in accordance with statutory accounting principals (SAP) that differ from Generally Accepted Accounting Principles (GAAP). Statutory accounting seeks to determine an insurer's ability to satisfy its obligations at all times, whereas GAPP measures the earnings of a company on a going-concern basis from period to period. Under SAP, most assets and liabilities are valued conservatively and

 

certain non-liquid assets, i.e., furniture and fixtures, are not admitted in the calculation of an insurer's surplus.

States typically prioritize the review of their domiciliary companies and any companies that require expedited scrutiny. Most departments utilize some system of financial ratios or other tools to screen and prioritize insurers for analysis. Regulators also utilize NAIC financial information systems including the Insurance Regulatory Information System (IRIS), which includes the Financial Analysis Solvency Tools (FAST) system, and other reports. Various additional sources of information may be tapped including: Securities and Exchange Commission (SEC) filings; claims-paying ability ratings; complaint ratios; market conduct reports; correspondence from competitors and agents; news articles; and other sources of anecdotal information.

## Other Measures

Market Assistance Plans or MAPs have been used successfully in several states. A MAP is an organized effort, typically a joint public-private endeavor, to match those having difficulty obtaining insurance with a willing insurer. The MAPs work very well when there are only minor market difficulties. The typical development of a MAP occurs when the insurance department and State Legislators receive complaints about either the availability or affordability of coverage that cannot be met by ordinary measures. Generally, discussion with the insurance industry will lead to an offer to host or participate in the MAP. Insurers are motivated to sell as much insurance as possible given financial, regulatory and market constraints. It is in their interest to cooperate with the

 

legislature to assist in making sure that the market is adequately served.

Most MAPs are voluntary in nature with participating insurers evaluating the risks presented to them to see if the particular piece of business can be placed. There is generally a high success rate because the insurers may be concerned about further regulatory or legislative actions. They are also motivated by profit potential and sometimes are able to work with those seeking coverage on loss control measures to improve the profit potential for the insurer. MAPs work best where insurers still have capacity to write new business at a rate acceptable to purchasers.

## RECOMMENDATIONS FOR FUTURE STUDY

One of the underlying themes in nearly every piece of literature reviewed for this study, as well as the authors' own experiences with developing the report, was the fact that medical malpractice data was inconsistent, incomplete, difficult to obtain and even more difficult to interpret. The authors of this report agree with the conclusions and recommendations contained in the study released in 2003 by the United States General Accounting Office (GAO). In the section titled Matter for Congressional Consideration, the GAO in its report observed, "a lack of necessary data has hindered and continues to hinder the efforts of Congress, state regulators, and others to carefully analyze the problem and the effectiveness of the solutions that have been tried. Because of the potential for future crises, and in order to facilitate the evaluation of legislative remedies put in place by various levels of government, Congress may want to consider taking steps to ensure that additional and better data are collected. Specifically, Congress may want to

 

consider encouraging the NAIC and state insurance regulators to identify the types of data that are necessary to properly evaluate the medical malpractice market—specifically, the frequency, severity and causes of losses—and begin collecting these data in a form that would allow appropriate analysis. Included in this process would be an analysis of the costs and benefits of collecting such data, as well as the extent to which some segments of this market are not captured by current data-gathering efforts. Such data could serve the interests of state and federal governments and allow both to better understand the causes of recurring crises in the medical malpractice insurance market and formulate the most appropriate and effective solutions.[73]"

The authors of this report did not study the effect of reinsurance pricing on primary medical liability providers, but note that there is some anecdotal evidence that reinsurance prices have increased. Further, evaluation of changes in insurer reserving practices was beyond the scope of the study.

## CONCLUSION

The NAIC draft team did not insert them yet.

[73] Medical Malpractice Insurance—Multiple Factors Have Contributed to Increased Premium Rates. July 29, 2003, GAO, Page 46.

 

Table 1 - Definitions of Major Rating Laws

| | |
|---|---|
| Prior Approval | Rates must be filed with and approved by the state insurance department before they can be used. Approval can be by means of a deemer provision, which indicates approval if rates are not denied within a specified number of days. |
| Modified Prior Approval | Rate revisions involving change in expense ratio or rate relativity require prior approval. Rate revisions based on experience only are subject to "file and use" laws. |
| Flex Rating | Prior approval of rates required only if they exceed a certain percentage above (and sometimes below) the previously filed rates. |
| File and Use | Rates must be filed with the state insurance department prior to their use. Specific approval is not required, but the department retains the right of subsequent disapproval. |
| Use and File | Rates must be filed with the state insurance department within a specified period after they have been placed in use. |
| No File | Rates are not required to be filed with or approved by the state insurance department. However, the company must maintain records of experience and other information used in developing the rates and makes these available to the commissioner upon his request. |

Source: National Association of Insurance Commissioners.

 

Table 2– Definition of Legal Insurance Ownership Types

| | |
|---|---|
| Stock Insurance Company | An insurance operation owned by stockholders, as contrasted to a mutual insurance company owned by its policyholders. Many major life insurers are mutual companies. Whereas, many leading property/casualty and multi-line insurers are stock insurance companies. |
| Mutual Insurance Company | An insurer that is owned by its policyholders—no stock is available for purchase on the stock exchanges. |
| Reciprocal Exchange | An unincorporated association where each insured technically provides insurance to all other insureds with the association. (Thus, each participant in the pool is both an insurer and an insured.) An attorney-in-fact administers the exchange by paying losses experienced by the exchange, investing, underwriting renewal business, receiving premiums, and purchasing reinsurance. Members share profits and losses in proportion to the amount of insurance purchased from the exchange by that member. |
| Surplus Lines (Aka. Excess-Surplus Lines or Non-Admitted) | A property or liability insurer that provides coverage on a non-admitted basis. State laws generally specify when policyholders can access the non-admitted insurer. This typically occurs in instances where coverage is unavailable from insurers licensed by the state. Examples of surplus lines are coverage for some environmental liability risks, directors' and officers' liabilities, or medical liability insurance. |
| Risk Retention Groups | A liability insurer that operates as a licensed casualty insurer one state, but is permitted to sell insurance in other states by the terms of the Liability Risk Retention Act. Similar to an assessable mutual. A medical provider must be an owner of the company to secure coverage from it. |
| Self Insurance (Often known as Retention) | Protecting against loss by setting aside one's own money. This can be done on a mathematical basis by establishing a separate fund into which funds are deposited periodically. Self-insurance can protect against high frequency, low-severity losses. To do this through an insurance company would mean paying a premium that includes loadings for general expenses, cost of putting the policy on the books, acquisition expenses, premium taxes, and contingencies. Often not accepted as valid proof of security by hospitals. |
| State Insurance Fund (Risk Retention Mechanisms) | Accounts established and administered by a state agency to finance an insurance program that provides an alternative to the other markets or serves as a market of last resort. |

Source: Dictionary of Insurance Terms - 2nd Ed. with edits done by the authors.

 

Table 3 - Direct Written Premium, Countrywide

(In 2002 $USD)

| Year | Number of Insurers | Total | Mean | Standard Deviation | Median | Maximum |
|---|---|---|---|---|---|---|
| 1991 | 257 | 6,665,549,348 | 25,935,990 | 55,441,013 | 4,588,622 | 526,154,768 |
| 1992 | 269 | 6,827,820,779 | 25,382,233 | 53,572,459 | 4,595,223 | 489,020,390 |
| 1993 | 266 | 6,775,072,896 | 25,470,199 | 56,426,506 | 4,617,686 | 532,449,918 |
| 1994 | 275 | 7,453,583,318 | 27,103,939 | 59,749,168 | 4,460,913 | 483,164,615 |
| 1995 | 271 | 7,276,853,911 | 26,851,859 | 57,824,871 | 4,611,617 | 408,509,288 |
| 1996 | 278 | 6,973,356,222 | 25,084,015 | 52,870,573 | 3,355,900 | 357,993,033 |
| 1997 | 280 | 6,662,691,234 | 23,795,326 | 50,157,760 | 3,384,353 | 369,535,567 |
| 1998 | 273 | 6,860,849,623 | 25,131,317 | 53,136,922 | 4,343,023 | 369,352,039 |
| 1999 | 272 | 6,658,823,288 | 24,480,968 | 51,735,283 | 4,491,573 | 403,190,447 |
| 2000 | 261 | 6,710,963,108 | 25,712,502 | 51,063,856 | 4,744,257 | 382,637,505 |
| 2001 | 247 | 7,675,911,761 | 31,076,566 | 64,066,916 | 4,992,833 | 475,708,456 |
| 2002 | 254 | 9,574,579,410 | 37,695,195 | 82,315,280 | 5,880,374 | 582,364,387 |

Source: National Association of Insurance Commissioners

 

## Table 4 – 2002 Direct Written Premium, By State

| State | Number of Insurers | Total | Mean | Standard Deviation | Median | Maximum |
|---|---|---|---|---|---|---|
| CW | — | 9,574,579,410 | 3,018,468 | 15,483,725 | 220,785 | 553,378,553 |
| AK | 39 | 16,122,037 | 413,386 | 993,849 | 48,451 | 4,411,104 |
| AL | 63 | 131,095,256 | 2,080,877 | 10,200,842 | 203,345 | 79,921,800 |
| AR | 59 | 59,218,826 | 1,003,709 | 3,005,255 | 123,319 | 21,552,547 |
| AZ | 74 | 204,489,742 | 2,763,375 | 12,084,311 | 381,781 | 102,954,827 |
| CA | 85 | 797,560,034 | 9,383,059 | 24,030,279 | 1,375,828 | 162,656,320 |
| CO | 67 | 117,207,767 | 1,749,370 | 7,034,831 | 220,703 | 56,520,290 |
| CT | 66 | 158,963,454 | 2,408,537 | 6,544,366 | 332,837 | 40,513,743 |
| DC | 41 | 38,400,641 | 936,601 | 3,423,222 | 77,137 | 21,673,080 |
| DE | 54 | 24,359,333 | 451,099 | 943,902 | 88,445 | 4,492,834 |
| FL | 84 | 829,122,375 | 9,870,504 | 24,974,713 | 1,037,225 | 169,558,079 |
| GA | 87 | 316,014,110 | 3,632,346 | 13,206,022 | 545,152 | 114,091,319 |
| HI | 45 | 37,412,921 | 831,398 | 2,209,323 | 103,586 | 10,363,609 |
| IA | 58 | 72,085,783 | 1,242,858 | 3,465,118 | 248,007 | 23,618,915 |
| ID | 58 | 27,290,061 | 470,518 | 1,154,792 | 71,207 | 5,757,509 |
| IL | 93 | 556,513,318 | 5,984,014 | 27,463,704 | 789,956 | 260,756,810 |
| IN | 65 | 88,244,233 | 1,357,604 | 5,609,614 | 96,498 | 38,201,527 |
| KS | 56 | 66,257,929 | 1,183,177 | 2,825,612 | 123,197 | 18,927,451 |
| KY | 63 | 124,214,360 | 1,971,657 | 4,092,046 | 550,000 | 25,688,878 |
| LA | 55 | 96,036,443 | 1,746,117 | 5,930,448 | 227,839 | 42,848,037 |
| MA | 59 | 239,205,217 | 4,054,326 | 15,267,493 | 506,395 | 108,618,293 |
| MD | 71 | 209,741,122 | 2,954,100 | 9,787,471 | 228,717 | 70,337,845 |
| ME | 45 | 40,149,330 | 892,207 | 3,607,411 | 97,916 | 23,848,816 |
| MI | 77 | 228,076,718 | 2,962,035 | 9,271,266 | 236,636 | 50,034,037 |
| MN | 62 | 68,274,668 | 1,101,204 | 4,567,107 | 197,038 | 35,523,012 |
| MO | 71 | 205,088,919 | 2,888,576 | 5,751,013 | 542,134 | 30,751,977 |
| MS | 58 | 63,682,554 | 1,097,975 | 2,982,240 | 161,346 | 20,226,392 |
| MT | 50 | 31,013,560 | 620,271 | 1,322,329 | 83,986 | 6,996,580 |

 

| State | Number of Insurers | Total | Mean | Standard Deviation | Median | Maximum |
|---|---|---|---|---|---|---|
| NC | 74 | 220,335,540 | 2,977,507 | 8,504,447 | 537,659 | 58,782,305 |
| ND | 40 | 17,470,320 | 436,758 | 1,563,873 | 29,137 | 9,726,301 |
| NE | 50 | 26,540,773 | 530,815 | 1,267,967 | 88,653 | 8,067,869 |
| NH | 47 | 37,018,240 | 787,622 | 1,718,955 | 143,932 | 9,807,879 |
| NJ | 74 | 415,863,902 | 5,619,782 | 25,159,410 | 332,697 | 202,205,541 |
| NM | 50 | 39,754,826 | 795,097 | 2,070,900 | 135,782 | 11,334,916 |
| NV | 55 | 81,083,027 | 1,474,237 | 2,794,247 | 190,598 | 11,551,776 |
| NY | 71 | 1,083,408,620 | 15,259,276 | 69,599,878 | 1,001,411 | 553,378,553 |
| OH | 86 | 463,957,147 | 5,394,851 | 16,513,593 | 360,748 | 92,401,161 |
| OK | 58 | 97,639,172 | 1,683,434 | 6,181,310 | 134,581 | 40,625,944 |
| OR | 64 | 86,865,176 | 1,357,268 | 4,105,857 | 194,466 | 23,286,219 |
| PA | 91 | 500,653,458 | 5,501,686 | 12,090,825 | 727,058 | 62,296,198 |
| RI | 48 | 33,184,328 | 691,340 | 2,247,873 | 62,714 | 13,929,010 |
| SC | 51 | 38,319,034 | 751,354 | 1,926,532 | 112,516 | 10,422,709 |
| SD | 38 | 15,382,127 | 404,793 | 1,613,746 | 43,129 | 9,918,472 |
| TN | 77 | 291,873,998 | 3,790,571 | 14,755,870 | 219,850 | 119,099,031 |
| TX | 93 | 634,060,733 | 6,817,857 | 17,057,174 | 1,227,553 | 111,224,733 |
| UT | 50 | 53,412,544 | 1,068,251 | 3,789,559 | 154,386 | 26,263,560 |
| VA | 77 | 181,492,012 | 2,357,039 | 3,998,870 | 407,481 | 14,858,688 |
| VT | 43 | 18,776,998 | 436,674 | 1,032,273 | 49,392 | 4,574,717 |
| WA | 76 | 198,970,549 | 2,618,034 | 8,344,035 | 248,867 | 65,992,394 |
| WI | 57 | 82,376,013 | 1,445,193 | 4,666,988 | 176,424 | 31,196,737 |
| WV | 59 | 91,990,983 | 1,559,169 | 4,927,226 | 126,777 | 29,549,566 |
| WY | 38 | 18,309,179 | 481,821 | 1,495,999 | 37,077 | 7,989,549 |

Source: National Association of Insurance Commissioners.

 

Table 5 - Direct Losses Incurred, Countrywide

(In 2002 $USD)

| Year | Number of Insurers | Total | Mean | Standard Deviation | Median | Maximum |
|---|---|---|---|---|---|---|
| 1991 | 257 | 3,759,089,886 | 14,626,809 | 35,190,859 | 1,963,228 | 215,044,544 |
| 1992 | 269 | 5,156,585,627 | 19,169,463 | 61,310,250 | 2,162,016 | 684,039,543 |
| 1993 | 266 | 4,365,893,562 | 16,413,134 | 42,064,490 | 2,064,689 | 397,703,575 |
| 1994 | 275 | 3,862,705,187 | 14,046,201 | 48,120,162 | 1,528,276 | 281,395,021 |
| 1995 | 271 | 3,932,152,619 | 14,509,788 | 46,153,127 | 2,462,594 | 300,941,799 |
| 1996 | 278 | 4,153,711,646 | 14,941,409 | 39,568,471 | 1,454,162 | 291,937,371 |
| 1997 | 280 | 3,588,222,339 | 12,815,080 | 35,781,569 | 1,684,074 | 222,867,768 |
| 1998 | 273 | 4,876,141,150 | 17,861,323 | 44,636,842 | 2,073,421 | 353,700,780 |
| 1999 | 272 | 4,969,949,146 | 18,271,872 | 42,389,413 | 2,796,390 | 319,508,466 |
| 2000 | 261 | 5,275,317,704 | 20,211,945 | 47,605,287 | 2,839,883 | 469,528,387 |
| 2001 | 247 | 7,013,509,025 | 28,394,773 | 66,639,109 | 3,517,091 | 534,825,400 |
| 2002 | 254 | 8,168,329,568 | 32,158,778 | 83,344,378 | 3,250,035 | 817,631,055 |

Source: National Association of Insurance Commissioners.

 

## Table 6 – 2002 Direct Losses Incurred, By State

| State | Number of Insurers | Total | Mean | Standard Deviation | Median | Maximum |
|---|---|---|---|---|---|---|
| AK | 39 | 8,778,063 | 225,079 | 660,790 | 14,312 | 2,085,402 |
| AL | 63 | 31,671,706 | 502,725 | 3,190,959 | 50,581 | 18,138,926 |
| AR | 59 | 78,703,998 | 1,333,966 | 3,727,644 | 59,366 | 22,012,748 |
| AZ | 74 | 168,337,412 | 2,274,830 | 6,866,072 | 274,126 | 51,638,359 |
| CA | 85 | 431,546,245 | 5,077,015 | 13,215,074 | 649,927 | 70,957,478 |
| CO | 67 | 69,005,399 | 1,029,931 | 3,281,436 | 46,986 | 20,045,355 |
| CT | 66 | 208,778,732 | 3,163,214 | 10,201,740 | 86,735 | 70,777,805 |
| DC | 41 | 28,797,229 | 702,371 | 2,431,976 | 8,270 | 9,668,857 |
| DE | 54 | 20,949,467 | 387,953 | 1,283,007 | 14,507 | 6,948,976 |
| FL | 84 | 787,527,502 | 9,375,327 | 19,718,551 | 930,172 | 94,069,722 |
| GA | 87 | 326,179,086 | 3,749,185 | 13,046,383 | 278,061 | 110,044,795 |
| HI | 45 | 17,088,075 | 379,735 | 1,094,973 | 18,945 | 5,778,568 |
| IA | 58 | 38,009,711 | 655,340 | 2,302,664 | 30,283 | 16,305,674 |
| ID | 58 | 25,168,306 | 433,936 | 1,070,147 | 15,270 | 5,550,183 |
| IL | 93 | 699,114,726 | 7,517,363 | 33,496,760 | 200,901 | 253,924,426 |
| IN | 65 | 46,759,712 | 719,380 | 2,616,165 | 17,023 | 16,011,881 |
| KS | 56 | 45,944,818 | 820,443 | 1,885,950 | 43,020 | 9,366,009 |
| KY | 63 | 87,916,721 | 1,395,504 | 3,569,074 | 152,190 | 22,533,147 |
| LA | 55 | 23,114,318 | 420,260 | 4,027,570 | 55,470 | 12,867,122 |
| MA | 59 | 225,295,679 | 3,818,571 | 16,704,142 | 69,886 | 116,229,237 |
| MD | 71 | 186,340,751 | 2,624,518 | 7,358,938 | 116,619 | 39,515,840 |
| ME | 45 | 22,628,831 | 502,863 | 2,972,450 | 11,438 | 18,820,774 |
| MI | 77 | 105,866,705 | 1,374,892 | 4,879,837 | 42,810 | 35,491,091 |
| MN | 62 | 32,889,494 | 530,476 | 3,364,464 | 11,729 | 25,974,463 |
| MO | 71 | 203,663,990 | 2,868,507 | 6,183,691 | 258,716 | 32,121,202 |
| MS | 58 | 82,669,845 | 1,425,342 | 4,083,930 | 74,808 | 25,886,398 |
| MT | 50 | 36,591,043 | 731,821 | 1,668,057 | 12,092 | 7,973,987 |
| NC | 74 | 142,117,114 | 1,920,502 | 5,040,753 | 136,083 | 29,634,587 |

 

| State | Number of Insurers | Total | Mean | Standard Deviation | Median | Maximum |
|---|---|---|---|---|---|---|
| ND | 40 | 10,789,929 | 269,748 | 1,476,586 | 5,081 | 9,197,441 |
| NE | 50 | 19,204,108 | 384,082 | 1,085,535 | 14,274 | 5,515,067 |
| NH | 47 | 16,996,065 | 361,618 | 921,717 | 24,311 | 3,194,903 |
| NJ | 74 | 378,672,136 | 5,117,191 | 23,000,634 | 100,157 | 162,522,895 |
| NM | 50 | 39,447,124 | 788,942 | 1,992,729 | 62,283 | 10,032,926 |
| NV | 55 | 116,638,935 | 2,120,708 | 6,327,141 | 129,263 | 43,888,646 |
| NY | 71 | 1,076,533,281 | 15,162,441 | 95,053,992 | 201,869 | 792,557,593 |
| OH | 86 | 382,431,886 | 4,446,882 | 14,234,553 | 113,750 | 100,302,134 |
| OK | 58 | 88,159,715 | 1,519,995 | 6,202,019 | 65,021 | 44,811,803 |
| OR | 64 | 61,210,060 | 956,407 | 3,406,385 | 44,318 | 20,373,027 |
| PA | 91 | 512,829,281 | 5,635,487 | 12,547,306 | 374,897 | 67,563,503 |
| RI | 48 | 26,901,061 | 560,439 | 2,211,470 | 15,666 | 12,621,173 |
| SC | 51 | 24,213,775 | 474,780 | 1,425,034 | 23,568 | 7,128,853 |
| SD | 38 | 9,695,167 | 255,136 | 986,563 | 1,934 | 5,639,567 |
| TN | 77 | 300,778,453 | 3,906,214 | 13,035,807 | 31,695 | 83,416,976 |
| TX | 93 | 467,042,795 | 5,021,966 | 12,904,885 | 532,992 | 84,715,898 |
| UT | 50 | 38,121,603 | 762,432 | 2,388,834 | 43,766 | 15,768,631 |
| VA | 77 | 112,655,221 | 1,463,055 | 3,059,641 | 118,085 | 15,341,571 |
| VT | 43 | 7,067,240 | 164,354 | 577,141 | 10,361 | 2,839,071 |
| WA | 76 | 161,978,737 | 2,131,299 | 7,614,739 | 81,263 | 45,993,898 |
| WI | 57 | 33,066,427 | 580,113 | 2,723,829 | 7,168 | 13,450,395 |
| WV | 59 | 92,795,829 | 1,572,811 | 5,605,903 | 68,210 | 34,047,063 |
| WY | 38 | 9,646,062 | 253,844 | 1,033,476 | 7,410 | 5,887,279 |

Source: National Association of Insurance Commissioners.

 

Table 7 - Direct Losses Paid, Countrywide

(In 2002 $USD)

| Year | Number of Insurers | Total | Mean | Standard Deviation | Median | Maximum |
|---|---|---|---|---|---|---|
| 1991 | 257 | 3,010,437,474 | 11,713,764 | 31,973,813 | 857,547 | 260,977,609 |
| 1992 | 269 | 3,574,163,795 | 13,286,854 | 36,884,642 | 1,462,454 | 356,848,985 |
| 1993 | 266 | 3,507,507,255 | 13,186,117 | 35,842,549 | 1,528,061 | 339,198,087 |
| 1994 | 275 | 3,878,312,269 | 14,102,954 | 35,453,023 | 1,223,833 | 290,449,596 |
| 1995 | 271 | 3,844,305,344 | 14,185,629 | 34,662,819 | 1,819,811 | 253,013,173 |
| 1996 | 278 | 4,004,181,852 | 14,403,532 | 35,473,376 | 1,421,175 | 276,124,446 |
| 1997 | 280 | 3,904,338,725 | 13,944,067 | 34,815,643 | 1,356,894 | 287,665,963 |
| 1998 | 273 | 4,358,813,681 | 15,966,350 | 38,757,999 | 1,232,259 | 331,181,009 |
| 1999 | 272 | 4,663,098,255 | 17,143,744 | 40,714,718 | 1,935,654 | 344,070,347 |
| 2000 | 261 | 5,059,430,144 | 19,384,790 | 47,283,645 | 2,052,602 | 344,142,438 |
| 2001 | 247 | 5,518,217,332 | 22,340,961 | 53,169,732 | 1,521,690 | 412,028,803 |
| 2002 | 254 | 5,905,829,834 | 23,251,299 | 68,852,863 | 1,660,748 | 836,133,767 |

Source: National Association of Insurance Commissioners.

 

## Table 8 – 2002 Direct Losses Paid, By State

| State | Number of Insurers | Total | Mean | Standard Deviation | Median | Maximum |
|---|---|---|---|---|---|---|
| | | 5,905,829,834 | 1,861,863 | 11,029,853 | 0 | 400,222,158 |
| AK | 39 | 7,771,836 | 199,278 | 503,649 | 0 | 2,054,427 |
| AL | 63 | 45,299,067 | 719,033 | 2,558,756 | 0 | 15,579,784 |
| AR | 59 | 45,827,139 | 776,731 | 2,410,138 | 0 | 16,518,721 |
| AZ | 74 | 148,556,698 | 2,007,523 | 6,968,141 | 105,869 | 54,142,976 |
| CA | 85 | 373,925,280 | 4,399,121 | 12,684,233 | 541,500 | 80,305,026 |
| CO | 67 | 55,212,247 | 824,063 | 3,551,222 | 0 | 25,972,589 |
| CT | 66 | 131,532,643 | 1,992,919 | 6,929,560 | 3,143 | 40,718,232 |
| DC | 41 | 26,335,674 | 642,334 | 2,348,070 | 0 | 10,976,650 |
| DE | 54 | 5,036,591 | 93,270 | 439,421 | 0 | 3,027,681 |
| FL | 84 | 613,735,851 | 7,306,379 | 15,793,157 | 655,979 | 89,974,454 |
| GA | 87 | 203,779,241 | 2,342,290 | 7,553,396 | 57,500 | 50,906,795 |
| HI | 45 | 16,004,268 | 355,650 | 1,269,553 | 0 | 6,790,903 |
| IA | 58 | 39,842,436 | 686,939 | 2,887,810 | 0 | 19,438,228 |
| ID | 58 | 14,130,403 | 243,628 | 1,002,814 | 0 | 6,981,905 |
| IL | 93 | 480,328,040 | 5,164,818 | 23,771,101 | 52,501 | 167,963,222 |
| IN | 65 | 20,275,397 | 311,929 | 947,501 | 0 | 5,025,000 |
| KS | 56 | 22,426,439 | 400,472 | 1,098,401 | 0 | 4,878,555 |
| KY | 63 | 54,844,033 | 870,540 | 2,798,648 | 0 | 19,453,108 |
| LA | 55 | 22,682,809 | 412,415 | 1,327,580 | 0 | 7,411,416 |
| MA | 59 | 131,756,629 | 2,233,163 | 11,025,298 | 3,500 | 77,497,468 |
| MD | 71 | 173,462,949 | 2,443,140 | 7,480,022 | 0 | 39,643,512 |
| ME | 45 | 14,005,668 | 311,237 | 1,386,007 | 0 | 9,055,942 |
| MI | 77 | 99,461,118 | 1,291,703 | 4,354,083 | 0 | 26,313,081 |
| MN | 62 | 38,730,671 | 624,688 | 2,813,183 | 0 | 18,638,037 |
| MO | 71 | 107,567,941 | 1,515,041 | 3,612,630 | 25,000 | 16,330,158 |
| MS | 58 | 70,109,340 | 1,208,782 | 5,907,313 | 0 | 43,795,733 |
| MT | 50 | 19,926,589 | 398,532 | 1,025,851 | 0 | 4,579,506 |

 

| State | Number of Insurers | Total | Mean | Standard Deviation | Median | Maximum |
|---|---|---|---|---|---|---|
| NC | 74 | 135,594,685 | 1,832,361 | 6,502,037 | 0 | 45,700,674 |
| ND | 40 | 6,949,970 | 173,749 | 557,034 | 0 | 2,752,732 |
| NE | 50 | 13,592,328 | 271,847 | 924,226 | 0 | 5,658,100 |
| NH | 47 | 16,842,492 | 358,351 | 995,853 | 0 | 5,477,114 |
| NJ | 74 | 259,842,946 | 3,511,391 | 18,679,588 | 0 | 122,307,556 |
| NM | 50 | 34,464,011 | 689,280 | 2,273,902 | 0 | 14,375,077 |
| NV | 55 | 61,748,840 | 1,122,706 | 4,350,619 | 0 | 21,113,457 |
| NY | 71 | 793,596,101 | 11,177,410 | 50,906,163 | 28,500 | 400,222,158 |
| OH | 86 | 216,674,467 | 2,519,471 | 8,408,281 | 225 | 53,543,524 |
| OK | 58 | 52,036,966 | 897,189 | 4,514,674 | 0 | 33,972,196 |
| OR | 64 | 39,208,418 | 612,632 | 2,484,946 | 0 | 14,305,437 |
| PA | 91 | 340,097,902 | 3,737,340 | 11,818,522 | 26,976 | 86,267,867 |
| RI | 48 | 7,744,931 | 161,353 | 555,974 | 0 | 3,041,218 |
| SC | 51 | 28,254,317 | 554,006 | 2,310,133 | 0 | 14,511,985 |
| SD | 38 | 7,168,645 | 188,649 | 763,492 | 0 | 4,491,264 |
| TN | 77 | 253,658,110 | 3,294,261 | 12,430,233 | 0 | 68,471,182 |
| TX | 93 | 342,166,935 | 3,679,214 | 8,666,776 | 812,000 | 48,010,589 |
| UT | 50 | 31,398,899 | 627,978 | 2,584,265 | 0 | 17,159,151 |
| VA | 77 | 74,984,221 | 973,821 | 2,342,216 | 3,000 | 15,051,465 |
| VT | 43 | 3,068,218 | 71,354 | 343,286 | 0 | 2,202,129 |
| WA | 76 | 115,554,395 | 1,520,453 | 5,593,393 | 0 | 40,157,273 |
| WI | 57 | 29,702,197 | 521,091 | 1,728,756 | 0 | 9,926,050 |
| WV | 59 | 49,710,574 | 842,552 | 3,555,635 | 0 | 21,587,639 |
| WY | 38 | 9,202,269 | 242,165 | 1,080,362 | 0 | 6,168,000 |

Source: National Association of Insurance Commissioners.

 

Table 9 - Defense and Cost Containment (DCC) Expenses Incurred, Countrywide

(In 2002 $USD)

| Year | Number of Insurers | Total | Mean | Standard Deviation | Median | Maximum |
|---|---|---|---|---|---|---|
| 1991 | 257 | 1,578,795,380 | 6,143,173 | 18,387,626 | 623,338 | 153,963,639 |
| 1992 | 269 | 1,731,263,220 | 6,435,923 | 18,527,596 | 702,849 | 184,021,278 |
| 1993 | 266 | 1,523,415,577 | 5,727,126 | 14,365,785 | 592,928 | 96,369,285 |
| 1994 | 275 | 1,558,932,983 | 5,668,847 | 14,266,831 | 623,706 | 105,038,406 |
| 1995 | 271 | 1,831,719,852 | 6,759,114 | 16,486,311 | 713,109 | 113,123,182 |
| 1996 | 278 | 1,608,130,260 | 5,784,641 | 14,076,320 | 489,402 | 94,531,348 |
| 1997 | 280 | 1,608,051,973 | 5,743,043 | 16,018,728 | 582,005 | 121,242,277 |
| 1998 | 273 | 1,701,528,420 | 6,232,705 | 15,403,414 | 617,612 | 106,436,015 |
| 1999 | 272 | 1,839,454,493 | 6,762,700 | 16,480,217 | 749,458 | 126,299,988 |
| 2000 | 261 | 1,708,456,451 | 6,545,810 | 14,267,949 | 1,054,255 | 111,361,434 |
| 2001 | 247 | 1,992,685,767 | 8,067,554 | 18,879,000 | 869,371 | 156,249,315 |
| 2002 | 254 | 2,421,160,448 | 9,532,128 | 21,741,088 | 1,308,129 | 170,224,576 |

Source: National Association of Insurance Commissioners.

 

Table 10 – 2002 Defense and Cost Containment (DCC) Expenses Incurred, By State

| State | Number of Insurers | Total | Mean | Standard Deviation | Median | Maximum |
|---|---|---|---|---|---|---|
| AK | 39 | 4,071,058 | 104,386 | 277,087 | 2,285 | 1,336,453 |
| AL | 63 | 53,512,843 | 849,410 | 5,519,091 | 9,202 | 43,784,219 |
| AR | 59 | 20,270,832 | 343,573 | 959,917 | 24,813 | 5,495,562 |
| AZ | 74 | 60,171,646 | 813,130 | 3,262,908 | 95,110 | 27,264,495 |
| CA | 85 | 278,413,337 | 3,275,451 | 9,343,542 | 312,897 | 62,425,291 |
| CO | 67 | 25,869,393 | 386,110 | 2,087,647 | 15,532 | 17,065,901 |
| CT | 66 | 41,376,576 | 626,918 | 2,024,499 | 45,218 | 13,284,455 |
| DC | 41 | 12,081,553 | 294,672 | 1,359,978 | 7,454 | 8,515,470 |
| DE | 54 | 6,779,356 | 125,544 | 422,046 | 9,475 | 2,677,105 |
| FL | 84 | 205,691,006 | 2,448,702 | 5,405,134 | 257,669 | 33,291,504 |
| GA | 87 | 71,518,077 | 822,047 | 2,665,279 | 121,734 | 23,134,788 |
| HI | 45 | 9,866,233 | 219,250 | 830,911 | 4,234 | 4,803,803 |
| IA | 58 | 10,965,286 | 189,057 | 526,995 | 16,406 | 3,287,346 |
| ID | 58 | 8,170,173 | 140,865 | 394,970 | 5,366 | 1,922,142 |
| IL | 93 | 138,553,354 | 1,489,821 | 7,949,624 | 71,733 | 75,593,535 |
| IN | 65 | 39,272,386 | 604,191 | 3,650,208 | 3,000 | 29,229,849 |
| KS | 56 | 21,350,042 | 381,251 | 857,064 | 16,226 | 5,140,295 |
| KY | 63 | 26,819,022 | 425,699 | 1,029,316 | 35,000 | 6,220,961 |
| LA | 55 | 42,374,076 | 770,438 | 3,136,911 | 26,649 | 22,574,801 |
| MA | 59 | 53,120,343 | 900,345 | 3,943,438 | 35,109 | 29,388,176 |
| MD | 71 | 37,155,582 | 523,318 | 1,255,062 | 30,281 | 7,509,628 |
| ME | 45 | 4,529,597 | 100,658 | 480,337 | 2,000 | 3,102,185 |
| MI | 77 | 37,336,544 | 484,890 | 1,855,962 | 20,438 | 11,881,401 |
| MN | 62 | 4,457,629 | 71,897 | 621,389 | 2,388 | 4,636,843 |
| MO | 71 | 52,691,307 | 742,131 | 1,645,468 | 102,750 | 8,542,865 |
| MS | 58 | 21,246,593 | 366,321 | 912,271 | 24,967 | 4,846,081 |
| MT | 50 | 9,291,756 | 185,835 | 445,091 | 4,770 | 1,933,125 |
| NC | 74 | 52,795,094 | 713,447 | 2,935,017 | 21,550 | 23,886,091 |

 

| State | Number of Insurers | Total | Mean | Standard Deviation | Median | Maximum |
|---|---|---|---|---|---|---|
| ND | 40 | 2,891,612 | 72,290 | 255,853 | 567 | 1,169,244 |
| NE | 50 | 7,111,293 | 142,226 | 355,088 | 2,238 | 2,008,574 |
| NH | 47 | 5,204,341 | 110,731 | 344,184 | 5,392 | 1,961,436 |
| NJ | 74 | 81,187,407 | 1,097,127 | 4,851,005 | 38,750 | 32,874,724 |
| NM | 50 | 10,329,755 | 206,595 | 713,680 | 24,422 | 4,846,447 |
| NV | 55 | 29,571,549 | 537,665 | 1,277,106 | 67,473 | 7,315,845 |
| NY | 71 | 272,570,672 | 3,839,024 | 20,950,172 | 55,172 | 160,400,139 |
| OH | 86 | 102,474,370 | 1,191,562 | 4,318,227 | 24,668 | 34,970,755 |
| OK | 58 | 33,897,570 | 584,441 | 2,467,400 | 11,608 | 16,996,508 |
| OR | 64 | 15,714,648 | 245,541 | 955,922 | 12,063 | 6,005,167 |
| PA | 91 | 143,400,398 | 1,575,829 | 4,159,095 | 67,827 | 29,201,813 |
| RI | 48 | 7,693,206 | 160,275 | 640,450 | 3,777 | 4,078,449 |
| SC | 51 | 3,230,242 | 63,338 | 476,979 | 4,210 | 2,862,110 |
| SD | 38 | 1,449,735 | 38,151 | 168,771 | 364 | 860,854 |
| TN | 77 | 63,489,999 | 824,545 | 4,103,422 | 11,077 | 33,614,040 |
| TX | 93 | 155,133,244 | 1,668,099 | 4,752,107 | 240,321 | 37,762,860 |
| UT | 50 | 14,903,678 | 298,074 | 1,324,472 | 9,795 | 9,215,377 |
| VA | 77 | 40,347,371 | 523,992 | 1,203,766 | 48,586 | 6,428,217 |
| VT | 43 | 2,943,611 | 68,456 | 215,564 | 1,477 | 1,029,763 |
| WA | 76 | 41,715,383 | 548,887 | 2,038,599 | 24,690 | 15,028,190 |
| WI | 57 | 9,341,767 | 163,891 | 1,604,158 | 3,840 | 8,143,210 |
| WV | 59 | 21,569,333 | 365,582 | 1,737,258 | 21,238 | 12,895,333 |
| WY | 38 | 5,238,570 | 137,857 | 670,822 | 1,940 | 4,108,633 |

Source: National Association of Insurance Commissioners.

 

Table 11 –Medical Liability Insurance Median Insurer Expenses, Countrywide

(In 2002 $USD)

| Year | Number of Insurers | Premium Earned | General Expenses | Pct. of Premium | Taxes, Licenses & Fees | Pct. of Premium | Commission and Brokerage Expense | Pct. of Premium |
|---|---|---|---|---|---|---|---|---|
| 1992 | 269 | 4,260,283 | 247,475 | 5.81% | 61,548 | 1.44% | 96,810 | 2.27% |
| 1993 | 266 | 4,683,625 | 262,691 | 5.61% | 74,699 | 1.59% | 114,538 | 2.45% |
| 1994 | 275 | 3,642,914 | 244,601 | 6.71% | 60,088 | 1.65% | 81,331 | 2.23% |
| 1995 | 271 | 4,507,534 | 354,134 | 7.86% | 63,744 | 1.41% | 132,800 | 2.95% |
| 1996 | 278 | 4,195,373 | 252,250 | 6.01% | 61,916 | 1.48% | 92,874 | 2.21% |
| 1997 | 280 | 3,361,496 | 205,120 | 6.10% | 42,593 | 1.27% | 86,307 | 2.57% |
| 1998 | 273 | 4,302,148 | 248,328 | 5.77% | 65,117 | 1.51% | 135,753 | 3.16% |
| 1999 | 272 | 4,346,863 | 225,145 | 5.18% | 49,132 | 1.13% | 114,462 | 2.63% |
| 2000 | 261 | 4,301,093 | 265,880 | 6.18% | 57,459 | 1.34% | 125,888 | 2.93% |
| 2001 | 247 | 4,940,901 | 204,178 | 4.13% | 85,328 | 1.73% | 154,403 | 3.13% |
| 2002 | 254 | 5,338,000 | 246,000 | 4.61% | 75,000 | 1.41% | 208,000 | 3.90% |

Source: National Association of Insurance Commissioners

 

Table 12 – Medical Liability Median Insurer Profitability, Countrywide

(In 2002 $USD)

| Year | Number of Insurers | Loss Ratio | Expense Ratio | Combined Ratio | Underwriting Profit | Pct. of Premium | Pretax Profit | Pct. of Premium | Total Profit (Loss) | Pct. of Premium |
|---|---|---|---|---|---|---|---|---|---|---|
| 1992 | 383 | 89.27% | 25.90% | 116.69% | -93,604 | (10.11%) | -88,475 | (9.56%) | 214,136 | 23.13% |
| 1993 | 367 | 77.65% | 22.98% | 98.92% | -3,735 | (0.38%) | -4,980 | (0.51%) | 197,952 | 20.08% |
| 1994 | 373 | 80.18% | 27.27% | 113.43% | -23,064 | (3.04%) | -14,567 | (1.92%) | 110,465 | 14.56% |
| 1995 | 370 | 82.74% | 27.92% | 114.05% | -66,695 | (8.03%) | -61,383 | (7.39%) | 118,045 | 14.20% |
| 1996 | 377 | 82.31% | 24.40% | 106.43% | -12,612 | (1.37%) | -18,345 | (1.99%) | 165,109 | 17.93% |
| 1997 | 374 | 90.71% | 25.42% | 116.59% | -105,362 | (11.25%) | -104,802 | (11.19%) | 42,593 | 4.55% |
| 1998 | 376 | 83.50% | 30.06% | 114.25% | -40,836 | (5.21%) | -39,181 | (5.00%) | 153,412 | 19.58% |
| 1999 | 347 | 93.57% | 29.46% | 124.02% | -204,088 | (13.91%) | -220,286 | (15.01%) | 35,634 | 2.43% |
| 2000 | 350 | 98.88% | 28.01% | 131.16% | -252,821 | (21.59%) | -258,567 | (22.08%) | 10,447 | 0.89% |
| 2001 | 314 | 103.45% | 25.48% | 130.76% | -435,783 | (25.86%) | -462,194 | (27.43%) | -26,411 | (1.57%) |
| 2002 | 309 | 103.58% | 25.61% | 122.18% | -604,000 | (32.47%) | -540,000 | (29.03%) | -46,000 | (2.47%) |

Source: National Association of Insurance Commissioners

 

## Table 13 – 2002 Medical Liability Profitability Results, By State

| State | Premium Earned (000's) | Losses Incurred* | Loss Adjustment Expense* | General Expenses* | Selling Expenses* | Taxes, Licenses & Fees* | Dividends To Policyholders* | Under-writing Profit* | Investment Gain* | Federal Tax* | Return on Net Worth* |
|---|---|---|---|---|---|---|---|---|---|---|---|
| AL | 123,351 | 38.2 | 43.1 | 7.5 | 5.2 | 2.7 | 0.2 | 3.1 | 24.4 | 7.7 | 13.6 |
| AK | 13,226 | 93.8 | 56.5 | 7.5 | 8.2 | 2.2 | 11.2 | -79.3 | 18.4 | -22.8 | -17.6 |
| AZ | 135,597 | 95.2 | 38.5 | 7.5 | 8.2 | 0.9 | 7.5 | -57.8 | 22.8 | -14.1 | -5.7 |
| AR | 39,727 | 189.6 | 52.3 | 7.5 | 10.8 | 2.6 | 1.5 | -164.1 | 25.6 | -50.6 | -35.1 |
| CA | 644,598 | 63.5 | 31.0 | 7.5 | 9.8 | 2.5 | 3.5 | -17.8 | 15.2 | -2.1 | 4.0 |
| CO | 97,668 | 46.1 | 37.8 | 7.5 | 6.4 | 1.2 | 9.5 | -8.4 | 18.8 | 2.1 | 8.9 |
| CT | 120,543 | 153.9 | 22.9 | 7.5 | 8.8 | 2.3 | 3.5 | -99.0 | 38.5 | -24.3 | -7.6 |
| DE | 17,215 | 109.2 | 27.6 | 7.5 | 14.8 | 1.9 | 0.1 | -61.2 | 19.9 | -16.1 | -8.9 |
| DC | 30,893 | 93.0 | 21.8 | 7.5 | 8.2 | 2.8 | 0.9 | -34.1 | 28.9 | -4.2 | 3.8 |
| FL | 604,014 | 120.8 | 37.6 | 7.5 | 10.4 | 2.0 | 0.2 | -78.5 | 18.4 | -22.5 | -17.4 |
| GA | 200,600 | 133.7 | 34.0 | 7.5 | 8.6 | 3.3 | 1.5 | -88.6 | 23.0 | -24.8 | -15.5 |
| HI | 30,092 | 67.1 | 96.4 | 7.5 | 7.5 | 5.5 | 1.0 | -85.0 | 19.0 | -24.6 | -18.7 |
| ID | 21,840 | 96.2 | 39.4 | 7.5 | 9.2 | 2.0 | 7.7 | -62.0 | 18.8 | -16.6 | -10.8 |
| IL | 399,142 | 124.1 | 38.7 | 7.5 | 9.9 | 0.7 | 0.2 | -81.1 | 27.2 | -21.0 | -10.1 |
| IN | 58,693 | 40.7 | 49.9 | 7.5 | 9.0 | 1.2 | 0.2 | -8.5 | 21.0 | 2.7 | 9.3 |
| IA | 58,831 | 76.5 | 21.9 | 7.5 | 8.1 | 1.7 | 3.3 | -19.0 | 13.6 | -3.0 | 2.6 |
| KS | 45,804 | 70.0 | 33.9 | 7.5 | 9.9 | 1.7 | 0.1 | -23.1 | 14.6 | -4.2 | 1.3 |
| KY | 81,826 | 80.5 | 41.1 | 7.5 | 9.5 | 3.1 | 0.3 | -41.9 | 25.9 | -7.7 | 0.5 |
| LA | 82,000 | 40.9 | 44.7 | 7.5 | 9.2 | 1.9 | 0.1 | -4.3 | 24.6 | 5.1 | 11.3 |
| ME | 27,055 | 101.8 | 24.3 | 7.5 | 8.4 | 2.2 | 0.6 | -44.8 | 18.3 | -10.7 | -4.4 |
| MD | 155,433 | 90.1 | 24.8 | 7.5 | 9.7 | 2.2 | 12.7 | -47.0 | 22.1 | -10.5 | -3.0 |
| MA | 182,898 | 113.0 | 26.2 | 7.5 | 9.7 | 2.7 | 7.3 | -66.3 | 43.5 | -11.5 | 0.9 |
| MI | 177,045 | 61.2 | 33.8 | 7.5 | 10.1 | 1.6 | 6.1 | -20.2 | 23.2 | -0.8 | 6.1 |
| MN | 56,147 | 102.3 | 18.8 | 7.5 | 8.9 | 2.1 | 10.5 | -50.1 | 12.2 | -14.3 | -13.5 |
| MS | 44,522 | 215.6 | 79.6 | 7.5 | 9.1 | 2.9 | 0.3 | -214.9 | 28.8 | -67.5 | -44.6 |
| MO | 119,300 | 85.9 | 30.6 | 7.5 | 11.5 | 2.0 | 1.7 | -39.1 | 20.2 | -8.2 | -1.4 |
| MT | 17,348 | 118.5 | 23.8 | 7.5 | 9.8 | 2.1 | 0.2 | -61.9 | 20.6 | -16.1 | -9.1 |
| NE | 22,359 | 38.7 | 28.1 | 7.5 | 10.5 | 1.7 | 0.8 | 12.7 | 19.3 | 9.7 | 16.5 |
| NV | 57,293 | 147.5 | 38.1 | 7.5 | 11.7 | 3.4 | 0.2 | -108.4 | 23.3 | -31.7 | -21.4 |
| NH | 19,296 | 90.8 | 20.8 | 7.5 | 12.2 | 5.8 | 0.3 | -37.4 | 21.1 | -7.4 | -0.1 |
| NJ | 290,103 | 82.6 | 26.1 | 7.5 | 10.5 | 1.4 | 0.1 | -28.2 | 27.7 | -2.4 | 5.0 |
| NM | 29,940 | 196.9 | 46.4 | 7.5 | 7.6 | 2.4 | 0.2 | -160.9 | 24.0 | -49.9 | -37.6 |
| NY | 888,290 | 105.2 | 28.2 | 7.5 | 5.2 | 2.7 | 7.0 | -55.7 | 39.9 | -8.7 | 1.9 |
| NC | 158,764 | 112.0 | 34.5 | 7.5 | 9.5 | 2.0 | 0.2 | -65.8 | 16.7 | -18.5 | -14.3 |
| ND | 12,887 | 77.3 | 28.5 | 7.5 | 11.8 | 2.2 | 5.0 | -32.2 | 16.8 | -6.8 | -1.0 |
| OH | 300,057 | 106.0 | 35.0 | 7.5 | 12.6 | 1.6 | 0.1 | -62.9 | 19.2 | -16.8 | -10.6 |
| OK | 63,526 | 90.2 | 43.5 | 7.5 | 8.4 | 2.4 | 0.2 | -52.1 | 24.5 | -11.6 | -3.4 |
| OR | 56,534 | 143.5 | 31.3 | 7.5 | 8.3 | 0.8 | 0.9 | -92.3 | 16.9 | -27.7 | -24.3 |
| PA | 335,491 | 141.4 | 40.1 | 7.5 | 8.6 | 2.0 | 0.1 | -99.6 | 25.4 | -28.0 | -16.9 |
| RI | 21,681 | 127.8 | 40.5 | 7.5 | 11.2 | 2.3 | 0.2 | -89.6 | 36.0 | -21.7 | -6.7 |
| SC | 23,587 | 96.7 | 41.8 | 7.5 | 11.0 | 2.3 | 0.2 | -59.4 | 17.9 | -16.0 | -10.5 |
| SD | 10,543 | 40.2 | 22.0 | 7.5 | 14.2 | 2.5 | 1.3 | 12.5 | 14.1 | 8.2 | 16.6 |
| TN | 250,361 | 98.9 | 32.4 | 7.5 | 5.9 | 1.3 | 5.7 | -51.6 | 20.8 | -12.4 | -5.5 |
| TX | 422,003 | 102.0 | 34.6 | 7.5 | 9.4 | 1.9 | 0.2 | -55.6 | 19.2 | -14.3 | -8.1 |
| UT | 37,152 | 103.6 | 32.3 | 7.5 | 7.9 | 0.8 | 0.2 | -52.2 | 23.8 | -11.9 | -3.9 |
| VT | 6,891 | 133.2 | 43.1 | 7.5 | 13.2 | 2.5 | 0.9 | -100.3 | 21.4 | -29.3 | -19.9 |
| VA | 141,345 | 89.8 | 44.1 | 7.5 | 9.3 | 2.2 | 0.2 | -53.1 | 17.2 | -13.9 | -8.8 |
| WA | 134,009 | 84.1 | 29.4 | 7.5 | 7.1 | 2.1 | 0.3 | -30.4 | 16.2 | -6.3 | -0.9 |
| WV | 76,937 | 91.4 | 51.8 | 7.5 | 11.3 | 4.3 | 0.1 | -66.3 | 20.0 | -17.8 | -11.1 |
| WI | 64,060 | 31.6 | 25.9 | 7.5 | 9.9 | 1.9 | 55.6 | -32.5 | 25.0 | -4.6 | 2.9 |
| WY | 10,594 | 93.5 | 20.6 | 7.5 | 11.5 | 1.8 | 0.2 | -35.1 | 14.6 | -8.4 | -3.6 |

* As a percent of net premiums earned.

Source: National Association of Insurance Commissioners.

 

## Table 14 - 2002 Medical Liability Combined Ratios, By State

| State | Direct Loss Incurred | Loss Adjustment Expense | Direct Premium Written | Combined Ratio | Losses Incurred To Premium | Loss Adjustment Expense to Premium |
|---|---|---|---|---|---|---|
| AK | 8,764,207 | 4,053,823 | 16,122,037 | 79.51% | 54.36% | 25.14% |
| AL | 35,261,548 | 53,889,393 | 130,730,124 | 68.19% | 26.97% | 41.22% |
| AR | 82,809,117 | 20,845,838 | 59,218,377 | 175.04% | 139.84% | 35.20% |
| AZ | 169,831,479 | 58,770,841 | 204,482,771 | 111.80% | 83.05% | 28.74% |
| CA | 433,980,863 | 279,433,208 | 797,541,264 | 89.45% | 54.41% | 35.04% |
| CO | 69,935,465 | 26,712,235 | 117,206,510 | 82.46% | 59.67% | 22.79% |
| CT | 209,284,110 | 42,347,315 | 158,914,049 | 158.34% | 131.70% | 26.65% |
| DC | 32,337,315 | 14,142,424 | 38,394,747 | 121.06% | 84.22% | 36.83% |
| DE | 19,898,940 | 5,530,189 | 24,233,473 | 104.93% | 82.11% | 22.82% |
| FL | 792,301,816 | 206,708,992 | 825,199,361 | 121.06% | 96.01% | 25.05% |
| GA | 325,580,234 | 71,930,417 | 315,957,472 | 125.81% | 103.05% | 22.77% |
| HI | 16,513,637 | 10,090,714 | 37,412,671 | 71.11% | 44.14% | 26.97% |
| IA | 37,260,117 | 10,814,555 | 72,085,105 | 66.69% | 51.69% | 15.00% |
| ID | 24,934,222 | 8,199,716 | 27,287,203 | 121.43% | 91.38% | 30.05% |
| IL | 765,171,330 | 145,423,794 | 556,039,958 | 163.76% | 137.61% | 26.15% |
| IN | 51,968,432 | 42,062,446 | 88,224,429 | 106.58% | 58.90% | 47.68% |
| KS | 45,778,831 | 21,339,955 | 66,253,237 | 101.31% | 69.10% | 32.21% |
| KY | 85,702,382 | 27,335,077 | 124,163,358 | 91.04% | 69.02% | 22.02% |
| LA | 24,411,602 | 40,167,454 | 95,960,952 | 67.30% | 25.44% | 41.86% |
| MA | 242,449,063 | 53,314,711 | 239,173,347 | 123.66% | 101.37% | 22.29% |
| MD | 189,342,913 | 37,145,077 | 209,685,185 | 108.01% | 90.30% | 17.71% |
| ME | 22,363,918 | 4,464,630 | 40,149,330 | 66.82% | 55.70% | 11.12% |
| MI | 107,350,456 | 36,538,338 | 227,537,271 | 63.24% | 47.18% | 16.06% |
| MN | 32,942,421 | 4,315,807 | 68,273,039 | 54.57% | 48.25% | 6.32% |
| MO | 206,411,788 | 55,467,791 | 205,019,484 | 127.73% | 100.68% | 27.05% |
| MS | 88,765,589 | 24,042,831 | 63,497,737 | 177.66% | 139.79% | 37.86% |
| MT | 36,477,518 | 9,270,234 | 30,996,208 | 147.59% | 117.68% | 29.91% |
| NC | 140,556,627 | 54,871,311 | 220,333,824 | 88.70% | 63.79% | 24.90% |
| ND | 11,387,673 | 3,127,663 | 17,458,468 | 83.14% | 65.23% | 17.91% |
| NE | 18,881,996 | 7,119,699 | 26,540,646 | 97.97% | 71.14% | 26.83% |
| NH | 17,853,696 | 5,962,161 | 36,493,181 | 65.26% | 48.92% | 16.34% |
| NJ | 377,640,469 | 81,332,170 | 415,860,504 | 110.37% | 90.81% | 19.56% |
| NM | 38,055,900 | 10,357,746 | 39,743,240 | 121.82% | 95.75% | 26.06% |
| NV | 119,424,770 | 30,284,394 | 81,012,956 | 184.80% | 147.41% | 37.38% |
| NY | 1,068,101,936 | 257,082,310 | 1,079,010,048 | 122.81% | 98.99% | 23.83% |
| OH | 379,326,283 | 108,528,926 | 460,549,633 | 105.93% | 82.36% | 23.57% |
| OK | 88,997,402 | 33,847,104 | 97,621,674 | 125.84% | 91.17% | 34.67% |
| OR | 64,066,119 | 16,468,846 | 86,864,695 | 92.71% | 73.75% | 18.96% |
| PA | 510,739,436 | 144,285,296 | 499,022,656 | 131.26% | 102.35% | 28.91% |
| RI | 27,093,730 | 7,228,928 | 33,089,645 | 103.73% | 81.88% | 21.85% |
| SC | 25,190,924 | 3,355,593 | 38,274,802 | 74.58% | 65.82% | 8.77% |
| SD | 9,669,251 | 1,441,409 | 15,377,269 | 72.25% | 62.88% | 9.37% |
| TN | 309,332,583 | 66,076,132 | 291,863,920 | 128.62% | 105.99% | 22.64% |
| TX | 469,282,412 | 161,27[illegible]495 | 633,658,064 | 99.50% | 74.06% | 25.44% |
| UT | 37,543,372 | 14,740,830 | 53,412,544 | 97.89% | 70.29% | 27.60% |
| VA | 142,078,285 | 44,444,409 | 181,476,921 | 102.78% | 78.29% | 24.49% |
| VT | 18,448,046 | 2,905,618 | 18,751,148 | 113.88% | 98.38% | 15.50% |
| WA | 164,442,772 | 43,362,823 | 198,969,784 | 104.44% | 82.65% | 21.79% |
| WI | 34,084,567 | 10,417,291 | 82,375,534 | 54.02% | 41.38% | 12.65% |
| WV | 93,857,290 | 21,952,298 | 91,978,370 | 125.91% | 102.04% | 23.87% |
| WY | 9,139,229 | 5,133,248 | 18,305,948 | 77.97% | 49.92% | 28.04% |
| CW | 8,333,024,081 | 2,449,911,505 | 9,557,804,173 | 112.82% | 87.19% | 25.63% |

Source: National Association of Insurance Commissioners.

 

Table 15 - 2002 Medical Liability Underwriting Profit and Return on Net Worth, By State

| State | Combined Ratio | Investment Gain To Earned Premium | Operating Ratio | Return on Net Worth |
|---|---|---|---|---|
| AK | 79.51% | 16.01% | 63.49% | 1.48% |
| AL | 68.19% | 21.63% | 46.57% | 3.77% |
| AR | 175.04% | 18.60% | 156.44% | (6.80%) |
| AZ | 111.80% | 16.18% | 95.61% | (2.07%) |
| CA | 89.45% | 10.48% | 78.97% | 0.69% |
| CO | 82.46% | 15.73% | 66.73% | 1.11% |
| CT | 158.34% | 25.43% | 132.91% | (1.79%) |
| DC | 121.06% | 22.21% | 98.85% | (1.21%) |
| DE | 104.93% | 13.02% | 91.91% | (1.56%) |
| FL | 121.06% | 13.79% | 107.28% | (3.10%) |
| GA | 125.81% | 17.70% | 108.11% | (3.58%) |
| HI | 71.11% | 15.08% | 56.03% | 2.86% |
| IA | 66.69% | 9.41% | 57.28% | 4.01% |
| ID | 121.43% | 14.55% | 106.87% | (2.52%) |
| IL | 163.76% | 21.34% | 142.43% | (4.89%) |
| IN | 106.58% | 15.14% | 91.44% | (1.28%) |
| KS | 101.31% | 10.28% | 91.03% | (1.05%) |
| KY | 91.04% | 17.47% | 73.57% | 0.51% |
| LA | 67.30% | 18.80% | 48.50% | 3.69% |
| MA | 123.66% | 33.66% | 90.00% | (0.10%) |
| MD | 108.01% | 14.36% | 93.65% | (1.85%) |
| ME | 66.82% | 11.81% | 55.01% | 3.48% |
| MI | 63.24% | 17.14% | 46.10% | 3.52% |
| MN | 54.57% | 8.21% | 46.36% | 4.85% |
| MO | 127.73% | 12.41% | 115.33% | (4.79%) |
| MS | 177.66% | 22.41% | 155.25% | (5.86%) |
| MT | 147.59% | 12.03% | 135.56% | (6.66%) |
| NC | 80.70% | 11.80% | 76.90% | 0.68% |
| ND | 83.14% | 10.21% | 72.94% | 1.49% |
| NE | 97.97% | 13.92% | 84.05% | 0.62% |
| NH | 65.26% | 9.72% | 55.54% | 2.63% |
| NJ | 110.37% | 20.47% | 89.90% | (1.20%) |
| NM | 121.82% | 17.03% | 104.78% | (2.63%) |
| NV | 184.80% | 16.33% | 168.47% | (6.69%) |
| NY | 122.81% | 31.85% | 90.97% | (0.19%) |
| OH | 105.93% | 14.48% | 91.45% | (2.21%) |
| OK | 125.84% | 15.74% | 110.10% | (2.54%) |
| OR | 92.71% | 14.71% | 78.01% | (1.28%) |
| PA | 131.26% | 17.63% | 113.63% | (2.95%) |
| RI | 103.73% | 23.84% | 79.89% | 0.34% |
| SC | 74.58% | 11.89% | 62.70% | 1.11% |
| SD | 72.25% | 6.78% | 65.47% | 2.84% |
| TN | 128.62% | 17.55% | 111.08% | (2.01%) |
| TX | 99.50% | 12.16% | 87.35% | (0.56%) |
| UT | 97.89% | 16.50% | 81.39% | 0.55% |
| VA | 102.78% | 13.87% | 88.91% | (1.15%) |
| VT | 113.88% | 9.23% | 104.65% | (3.88%) |
| WA | 104.44% | 11.19% | 93.25% | (1.62%) |
| WI | 54.02% | 17.36% | 36.66% | 1.46% |
| WV | 125.91% | 14.59% | 111.32% | (1.31%) |
| WY | 77.97% | 7.96% | 70.00% | (0.08%) |

Source: National Association of Insurance Commissioners.

 

Table 16 - Analysis of Total Invested Asset Valuation, Countrywide

Insurers with >50% of Business in Medical Liability Insurance

| Year | Number of Insurers | Total | Mean | Standard Deviation | Median | Maximum |
|---|---|---|---|---|---|---|
| 1991 | 120 | 24,494,697,087 | 204,122,476 | 403,434,287 | 63,271,649 | 3,466,594,255 |
| 1992 | 130 | 26,880,912,522 | 206,776,250 | 402,722,110 | 65,890,296 | 3,574,874,240 |
| 1993 | 125 | 26,929,358,937 | 215,434,871 | 422,179,073 | 61,286,757 | 3,697,185,665 |
| 1994 | 126 | 30,818,377,700 | 244,590,299 | 463,973,555 | 65,992,100 | 3,701,295,861 |
| 1995 | 127 | 31,608,940,803 | 248,889,298 | 485,915,755 | 62,353,979 | 3,888,181,449 |
| 1996 | 129 | 32,320,614,955 | 250,547,403 | 488,202,042 | 61,980,383 | 3,853,146,654 |
| 1997 | 127 | 32,217,471,831 | 253,680,881 | 511,483,439 | 54,054,253 | 4,072,242,532 |
| 1998 | 115 | 32,809,721,529 | 285,301,926 | 534,344,856 | 79,420,644 | 3,888,316,542 |
| 1999 | 116 | 32,250,255,261 | 278,019,442 | 533,435,098 | 65,360,939 | 4,091,048,990 |
| 2000 | 106 | 27,801,184,057 | 262,275,321 | 493,371,610 | 67,786,176 | 3,989,543,546 |
| 2001 | 100 | 26,636,826,620 | 266,368,266 | 534,794,772 | 62,635,457 | 4,327,580,462 |
| 2002 | 115 | 26,626,881,655 | 231,538,101 | 496,442,889 | 44,777,217 | 4,203,373,647 |

Source: National Association of Insurance Commissioners.

 

Table 17 –Median Insurer Invested Asset Value by Type of Asset, Countrywide
Insurers with 50% of More of Their Business in Medical Liability Insurance

| Year | Total Invested Assets | Bonds | Cash & Short-Term Investments | Common & Preferred Stock | Other Invested Assets |
|---|---|---|---|---|---|
| 1991 | 63,271,649 | 48,370,502 | 6,109,895 | 609,821 | 0 |
| 1992 | 65,890,296 | 51,054,708 | 5,715,585 | 353,476 | 0 |
| 1993 | 61,266,757 | 54,364,800 | 5,482,865 | 1,032,473 | 0 |
| 1994 | 65,992,100 | 54,462,212 | 4,684,198 | 1,064,996 | 0 |
| 1995 | 62,353,979 | 48,622,546 | 4,531,922 | 817,352 | 0 |
| 1996 | 61,980,383 | 42,725,736 | 4,359,789 | 1,451,954 | 0 |
| 1997 | 54,054,253 | 38,747,206 | 4,613,931 | 1,636,210 | 0 |
| 1998 | 79,420,644 | 57,759,201 | 4,601,308 | 5,504,295 | 0 |
| 1999 | 65,360,939 | 54,068,225 | 3,706,911 | 4,180,907 | 0 |
| 2000 | 67,786,176 | 54,327,139 | 3,402,538 | 3,928,709 | 28,862 |
| 2001 | 62,635,457 | 50,577,881 | 5,630,883 | 2,349,735 | 0 |
| 2002 | 44,777,217 | 35,705,869 | 6,799,217 | 1,416,863 | 0 |

Source: National Association of Insurance Commissioners.

 

Table 18 –Invested Assets as a Percent of Total, Countrywide

Insurers with 50% of More of Their Business in Medical Liability Insurance

| Year | Total Invested Assets | Bonds | Cash and Short-Term Investments | Common & Preferred Stock | Other Invested Assets |
|---|---|---|---|---|---|
| 1991 | 63,271,649 | 83.26% | 10.38% | 0.43% | 0.00% |
| 1992 | 65,890,296 | 83.49% | 9.89% | 0.58% | 0.00% |
| 1993 | 61,286,757 | 82.42% | 9.04% | 2.09% | 0.00% |
| 1994 | 65,992,100 | 81.47% | 8.54% | 3.30% | 0.00% |
| 1995 | 62,353,979 | 80.61% | 8.21% | 3.38% | 0.00% |
| 1996 | 61,980,383 | 81.38% | 7.95% | 5.02% | 0.00% |
| 1997 | 54,054,253 | 80.15% | 7.77% | 5.00% | 0.00% |
| 1998 | 79,420,644 | 81.85% | 6.18% | 7.71% | 0.00% |
| 1999 | 65,360,939 | 81.46% | 6.06% | 5.64% | 0.00% |
| 2000 | 67,786,176 | 80.18% | 7.14% | 5.39% | 0.02% |
| 2001 | 62,635,457 | 79.75% | 9.29% | 4.13% | 0.00% |
| 2002 | 44,777,217 | 74.81% | 13.29% | 3.05% | 0.00% |

Source: National Association of Insurance Commissioners.

 

Table 19 - Analyses of Total Capital Gains (Losses)

Insurers with >50% of Business in Medical Liability Insurance

| Year | Number of Insurers | Sum | Median | Mean | Std Dev | Minimum | Maximum |
|---|---|---|---|---|---|---|---|
| 1991 | 98 | 295,630,667 | 749,693 | 3,016,639 | 6,122,614 | 212 | 44,753,918 |
| 1992 | 109 | 483,441,654 | 777,215 | 4,435,245 | 13,373,603 | 14 | 130,607,250 |
| 1993 | 104 | 564,664,401 | 1,258,664 | 5,429,465 | 12,954,221 | 135 | 101,712,447 |
| 1994 | 84 | 144,086,864 | 171,136 | 1,715,320 | 5,385,191 | 190 | 42,799,576 |
| 1995 | 111 | 510,195,186 | 747,564 | 4,596,353 | 11,172,709 | 1,500 | 88,201,970 |
| 1996 | 112 | 461,783,182 | 362,740 | 4,123,064 | 11,520,486 | 94 | 87,510,082 |
| 1997 | 107 | 713,401,516 | 829,660 | 6,667,304 | 20,449,728 | 1,065 | 156,970,930 |
| 1998 | 110 | 659,457,488 | 864,150 | 5,995,068 | 15,578,301 | 331 | 132,254,220 |
| 1999 | 89 | 660,808,320 | 986,655 | 7,424,813 | 17,484,159 | 147 | 128,919,597 |
| 2000 | 74 | 287,792,134 | 368,006 | 3,889,083 | 14,845,542 | 70 | 111,205,911 |
| 2001 | 85 | 320,574,470 | 752,238 | 3,771,464 | 12,089,014 | 293 | 105,209,115 |
| 2002 | 94 | -435,995,555 | -222,474 | -4,638,251 | 22,564,124 | -168,646,379 | 47,013,226 |

Source: National Association of Insurance Commissioners.

 

Table 20 - Total Investment Income Analyses, Countrywide
Insurers with >50% of Business in Medical Liability Insurance

| Year | Sum | Median | Mean | Standard Deviation |
|---|---|---|---|---|
| 1991 | 1,347,691,563 | 3,426,802 | 11,230,763 | 22,680,762 |
| 1992 | 1,423,044,170 | 3,706,093 | 10,946,494 | 21,328,337 |
| 1993 | 1,321,163,500 | 3,260,011 | 10,569,308 | 21,183,474 |
| 1994 | 1,484,392,871 | 3,316,313 | 11,780,896 | 22,236,704 |
| 1995 | 1,624,970,897 | 3,288,262 | 12,795,046 | 25,200,194 |
| 1996 | 1,686,003,512 | 3,211,232 | 13,069,795 | 25,376,231 |
| 1997 | 1,635,365,011 | 2,736,183 | 12,876,890 | 25,135,766 |
| 1998 | 1,622,862,126 | 3,685,234 | 14,111,845 | 26,150,269 |
| 1999 | 1,585,505,068 | 3,372,125 | 13,668,147 | 24,931,462 |
| 2000 | 1,478,866,495 | 4,512,703 | 13,951,571 | 24,431,705 |
| 2001 | 1,390,263,184 | 3,446,759 | 13,902,632 | 25,780,373 |
| 2002 | 1,240,418,990 | 2,132,924 | 10,786,252 | 21,262,188 |

Source: National Association of Insurance Commissioners.

 

Table 21 – Median Insurer Investment Income By Investment Type, Countrywide

Insurers with >50% of Business in Medical Liability Insurance

| Year | Bonds | Cash and Short-Term Investments | Common Stocks | Mortgages and Real Estate | Other Investment Income | Preferred Stocks |
|---|---|---|---|---|---|---|
| 1991 | 73,564 | 67,868 | 0 | 0 | 0 | 0 |
| 1992 | 93,154 | 40,392 | 0 | 0 | 0 | 0 |
| 1993 | 101,840 | 25,726 | 0 | 0 | 0 | 0 |
| 1994 | 107,960 | 34,367 | 0 | 0 | 0 | 0 |
| 1995 | 102,729 | 47,296 | 0 | 0 | 0 | 0 |
| 1996 | 119,234 | 42,206 | 0 | 0 | 0 | 0 |
| 1997 | 131,280 | 44,201 | 0 | 0 | 0 | 0 |
| 1998 | 158,568 | 61,226 | 0 | 0 | 0 | 0 |
| 1999 | 183,351 | 51,713 | 0 | 0 | 0 | 0 |
| 2000 | 176,929 | 89,665 | 0 | 0 | 0 | 0 |
| 2001 | 119,374 | 61,516 | 0 | 0 | 0 | 0 |
| 2002 | 19,445 | 85,588 | 0 | 0 | 0 | 0 |

Source: National Association of Insurance Commissioners.

 

Table 22 – Total Investment Income By Investment Type, Countrywide

Insurers with >50% of Business in Medical Liability Insurance

| Year | Bonds | Cash and Short-Term Investments | Common Stocks | Mortgages and Real Estate | Other Investment Income | Preferred Stocks | All |
|---|---|---|---|---|---|---|---|
| 1991 | 1,187,775,100 | 87,974,998 | 24,012,688 | 14,018,031 | 3,213,316 | 30,697,430 | 1,347,691,563 |
| 1992 | 1,258,679,059 | 70,789,183 | 34,457,897 | 15,873,686 | 8,398,702 | 34,845,643 | 1,423,044,170 |
| 1993 | 1,170,202,446 | 61,212,542 | 27,933,430 | 17,875,723 | 8,014,428 | 35,924,931 | 1,321,163,500 |
| 1994 | 1,308,551,241 | 78,204,872 | 40,131,574 | 16,725,851 | 3,819,515 | 36,959,818 | 1,484,392,871 |
| 1995 | 1,382,894,229 | 126,289,116 | 50,229,244 | 17,250,737 | 5,356,698 | 42,950,873 | 1,624,970,897 |
| 1996 | 1,451,427,500 | 88,500,423 | 55,941,274 | 17,037,988 | 36,466,737 | 36,629,590 | 1,686,003,512 |
| 1997 | 1,436,247,653 | 81,897,349 | 48,961,074 | 16,725,094 | 12,983,718 | 38,550,123 | 1,635,365,011 |
| 1998 | 1,410,382,527 | 100,433,295 | 41,881,420 | 15,944,300 | 15,056,703 | 39,163,881 | 1,622,862,126 |
| 1999 | 1,383,039,370 | 80,705,260 | 56,951,101 | 15,012,278 | 12,836,594 | 36,960,465 | 1,585,505,068 |
| 2000 | 1,302,340,754 | 84,826,154 | 28,699,420 | 17,392,676 | 8,138,881 | 37,468,610 | 1,478,866,495 |
| 2001 | 1,243,598,329 | 69,687,107 | 19,291,114 | 16,368,904 | 10,902,604 | 30,415,126 | 1,390,263,184 |
| 2002 | 1,133,718,847 | 38,362,527 | 23,260,624 | 14,095,573 | 4,258,388 | 26,723,031 | 1,240,418,990 |

Source: National Association of Insurance Commissioners.

 

Table 23 – Percent of Investment Income By Investment Type, Countrywide

Insurers with >50% of Business in Medical Liability Insurance

| Year | Bonds | Cash and Short-Term Investments | Common Stocks | Mortgages and Real Estate | Other Investment Income | Preferred Stocks |
|---|---|---|---|---|---|---|
| 1991 | 88.13 | 6.53 | 1.78 | 1.04 | 0.24 | 2.28 |
| 1992 | 88.45 | 4.97 | 2.42 | 1.12 | 0.59 | 2.45 |
| 1993 | 88.57 | 4.63 | 2.11 | 1.35 | 0.61 | 2.72 |
| 1994 | 88.15 | 5.27 | 2.70 | 1.13 | 0.26 | 2.49 |
| 1995 | 85.10 | 7.77 | 3.09 | 1.06 | 0.33 | 2.64 |
| 1996 | 86.09 | 5.25 | 3.32 | 1.01 | 2.16 | 2.17 |
| 1997 | 87.82 | 5.01 | 2.99 | 1.02 | 0.79 | 2.36 |
| 1998 | 86.91 | 6.19 | 2.58 | 0.98 | 0.93 | 2.41 |
| 1999 | 87.23 | 5.09 | 3.59 | 0.95 | 0.81 | 2.33 |
| 2000 | 88.06 | 5.74 | 1.94 | 1.18 | 0.55 | 2.53 |
| 2001 | 89.45 | 5.01 | 1.39 | 1.18 | 0.78 | 2.19 |
| 2002 | 91.40 | 3.09 | 1.88 | 1.14 | 0.34 | 2.15 |

Source: National Asscciation of Insurance Commissioners.

 

## Table 24 - Policyholder Surplus, Countrywide

(In 2002 $USD)

| Year | Number of Insurers | Total | Mean | Standard Deviation | Median | Minimum | Maximum |
|---|---|---|---|---|---|---|---|
| 1991 | 257 | 6,590,434,518,496 | 25,643,714,080 | 68,542,958,597 | 3,662,190,818 | -85,903,126,127 | 534,993,035,315 |
| 1992 | 269 | 6,781,787,508,430 | 25,211,105,979 | 64,599,076,700 | 4,161,544,647 | -106,639,066,303 | 439,970,278,342 |
| 1993 | 266 | 7,582,610,394,690 | 28,506,054,115 | 73,318,492,703 | 4,435,310,166 | -87,018,524,674 | 519,890,790,953 |
| 1994 | 275 | 8,618,140,861,949 | 31,453,068,839 | 80,667,933,269 | 4,855,128,182 | -9,700,046,125 | 593,738,393,063 |
| 1995 | 271 | 9,835,307,042,275 | 36,427,063,120 | 96,333,020,463 | 5,514,915,716 | -2,845,279,958 | 645,926,277,665 |
| 1996 | 278 | 11,309,522,892,499 | 40,681,737,023 | 109,993,458,473 | 6,622,037,772 | -5,591,755,334 | 764,468,079,784 |
| 1997 | 280 | 14,043,718,344,425 | 50,156,136,944 | 153,634,380,290 | 7,487,138,579 | -4,090,985,784 | 1,296,748,589,633 |
| 1998 | 273 | 16,134,536,487,275 | 59,100,866,254 | 180,327,720,399 | 8,776,901,260 | -5,597,195,712 | 1,505,980,769,638 |
| 1999 | 272 | 14,693,627,255,010 | 54,020,688,438 | 161,770,910,659 | 9,350,825,423 | -7,818,357,905 | 1,234,888,922,436 |
| 2000 | 261 | 12,659,434,323,161 | 48,503,579,782 | 149,578,042,285 | 8,320,452,416 | -22,297,335,253 | 1,144,362,536,974 |
| 2001 | 247 | 11,876,985,623,826 | 48,084,962,040 | 144,653,586,743 | 7,863,731,807 | -30,151,756,712 | 1,135,337,144,788 |
| 2002 | 254 | 12,401,730,219,976 | 48,825,709,527 | 148,692,937,955 | 7,693,268,246 | -37,705,821,717 | 1,058,721,694,753 |

Source: National Association of Insurance Commissioners.

 

Table 25 – Policyholder Surplus to Total Assets, Countrywide

| Year | Number of Insurers | Mean | Standard Deviation | Median | Minimum | Maximum | Number of Insurers with Ratio <= 5% |
|---|---|---|---|---|---|---|---|
| 1991 | 257 | 33.09% | 23.28% | 26.21% | (53.28%) | 100.01% | 5 |
| 1992 | 269 | 32.63% | 25.33% | 27.28% | (140.47%) | 100.25% | 7 |
| 1993 | 266 | 32.85% | 24.45% | 27.95% | (136.22%) | 100.01% | 8 |
| 1994 | 275 | 36.22% | 23.25% | 29.17% | (19.41%) | 100.00% | 5 |
| 1995 | 271 | 38.69% | 23.42% | 31.60% | (11.22%) | 101.73% | 3 |
| 1996 | 278 | 39.54% | 26.60% | 33.35% | (181.67%) | 99.97% | 5 |
| 1997 | 280 | 43.59% | 24.17% | 35.74% | (17.97%) | 99.96% | 3 |
| 1998 | 273 | 43.53% | 22.99% | 36.45% | (27.38%) | 99.99% | 2 |
| 1999 | 272 | 45.56% | 25.01% | 37.69% | (48.43%) | 100.04% | 4 |
| 2000 | 261 | 44.40% | 30.60% | 35.92% | (211.48%) | 100.00% | 4 |
| 2001 | 247 | 40.83% | 26.94% | 31.24% | (44.90%) | 112.82% | 6 |
| 2002 | 254 | 40.90% | 27.02% | 31.08% | (40.76%) | 100.00% | 4 |

Source: National Association of Insurance Commissioners.

 

Table 26 - Market Concentration Ratios, Countrywide

| Year | Number of Insurers | Mkt. Share of 4 Largest Insurers | Mkt. Share Of 8 Largest Insurers | Mkt. Share Of 20 Largest Insurers | Herfindahl-Hirschman Index |
|---|---|---|---|---|---|
| 1991 | 266 | 20.61% | 31.41% | 52.90% | 217.55 |
| 1992 | 271 | 19.23% | 30.66% | 51.22% | 202.28 |
| 1993 | 274 | 21.11% | 32.86% | 52.71% | 221.65 |
| 1994 | 279 | 20.02% | 32.17% | 54.59% | 213.89 |
| 1995 | 279 | 19.85% | 31.74% | 54.61% | 207.67 |
| 1996 | 281 | 17.95% | 29.88% | 54.14% | 195.19 |
| 1997 | 284 | 18.15% | 30.39% | 52.97% | 194.39 |
| 1998 | 277 | 18.03% | 31.15% | 54.41% | 200.68 |
| 1999 | 278 | 18.63% | 31.34% | 53.24% | 200.73 |
| 2000 | 268 | 18.34% | 29.46% | 51.00% | 189.69 |
| 2001 | 254 | 20.38% | 30.99% | 54.55% | 212.06 |
| 2002 | 261 | 21.68% | 33.03% | 56.00% | 227.13 |

Source: National Association of Insurance Commissioners.

 

Table 27 - 2002 Total, Mean & Median Insurer Direct Premium Written, By State

| State | Direct Premium Written | Number Of Insurers | Mean Premium Written | Median Premium Written |
|---|---|---|---|---|
| AK | 16,122,037 | 39 | 413,386 | 48,451 |
| AL | 130,730,124 | 67 | 1,951,196 | 153,826 |
| AR | 59,218,377 | 60 | 986,973 | 122,900 |
| AZ | 204,482,771 | 76 | 2,690,563 | 304,963 |
| CA | 797,541,264 | 88 | 9,062,969 | 1,265,103 |
| CO | 117,206,510 | 68 | 1,723,625 | 213,706 |
| CT | 158,914,049 | 69 | 2,303,102 | 303,112 |
| DC | 38,394,747 | 44 | 872,608 | 63,491 |
| DE | 24,233,473 | 56 | 432,741 | 84,063 |
| FL | 825,199,361 | 89 | 9,271,903 | 940,215 |
| GA | 315,957,472 | 91 | 3,472,060 | 413,897 |
| HI | 37,412,671 | 47 | 796,014 | 84,281 |
| IA | 72,085,105 | 59 | 1,221,781 | 247,980 |
| ID | 27,287,203 | 60 | 454,787 | 58,963 |
| IL | 556,039,958 | 102 | 5,451,372 | 405,876 |
| IN | 88,224,429 | 68 | 1,297,418 | 84,054 |
| KS | 66,253,237 | 59 | 1,122,936 | 107,435 |
| KY | 124,163,358 | 65 | 1,910,206 | 481,385 |
| LA | 95,960,952 | 57 | 1,683,525 | 227,127 |
| MA | 239,173,347 | 61 | 3,920,875 | 429,355 |
| MD | 209,685,185 | 77 | 2,723,184 | 187,221 |
| ME | 40,149,330 | 45 | 892,207 | 97,916 |
| MI | 227,537,271 | 82 | 2,774,845 | 179,251 |
| MN | 68,273,039 | 64 | 1,066,766 | 183,355 |
| MO | 205,019,484 | 75 | 2,733,593 | 490,000 |
| MS | 63,497,737 | 61 | 1,040,947 | 121,424 |
| MT | 30,996,208 | 52 | 590,081 | 66,672 |
| NC | 220,333,824 | 75 | 2,937,784 | 527,662 |
| ND | 17,458,468 | 43 | 406,011 | 25,118 |
| NE | 26,540,646 | 51 | 520,405 | 71,936 |
| NH | 36,493,181 | 49 | 744,759 | 118,408 |
| NJ | 415,860,504 | 75 | 5,544,807 | 375,417 |
| NM | 39,743,240 | 52 | 764,293 | 126,837 |
| NV | 81,012,956 | 58 | 1,396,775 | 149,782 |
| NY | 1,079,010,048 | 73 | 14,780,960 | 912,327 |
| OH | 460,549,633 | 92 | 5,005,974 | 287,973 |
| OK | 97,621,674 | 60 | 1,627,028 | 117,790 |
| OR | 86,864,695 | 66 | 1,316,132 | 187,380 |
| PA | 499,022,656 | 95 | 5,252,870 | 582,040 |
| RI | 33,089,645 | 50 | 661,793 | 50,175 |
| SC | 38,274,802 | 55 | 695,905 | 98,123 |
| SD | 15,377,269 | 41 | 375,055 | 39,998 |
| TN | 291,863,920 | 79 | 3,694,480 | 198,864 |
| TX | 633,658,064 | 99 | 6,400,587 | 785,312 |
| UT | 53,412,544 | 50 | 1,068,251 | 154,386 |
| VA | 181,476,921 | 79 | 2,297,176 | 383,944 |
| VT | 18,751,148 | 46 | 407,634 | 41,220 |
| WA | 198,969,784 | 77 | 2,584,023 | 231,899 |
| WI | 82,375,534 | 59 | 1,396,195 | 150,000 |
| WV | 91,978,370 | 62 | 1,483,522 | 109,161 |
| WY | 18,305,948 | 40 | 457,649 | 32,854 |

Source: National Association of Insurance Commissioners.

 

## Table 28 - 2002 Market Concentration Ratios, By State

| Year | Number of Insurers | Mkt. Share of 4 Largest Insurers | Mkt. Share Of 8 Largest Insurers | Mkt. Share Of 20 Largest Insurers | Herfindahl-Hirschman Index |
|---|---|---|---|---|---|
| AK | 39 | 70.64% | 86.86% | 98.38% | 1700.47 |
| AL | 67 | 80.85% | 87.92% | 95.94% | 3934.65 |
| AR | 60 | 61.89% | 79.58% | 95.25% | 1663.24 |
| AZ | 76 | 67.11% | 77.51% | 91.99% | 2684.63 |
| CA | 88 | 51.72% | 66.40% | 87.38% | 880.24 |
| CO | 68 | 69.14% | 80.27% | 93.29% | 2526.91 |
| CT | 69 | 60.53% | 75.18% | 92.93% | 1253.97 |
| DC | 44 | 79.23% | 88.96% | 98.68% | 3423.68 |
| DE | 56 | 56.58% | 77.47% | 94.05% | 991.46 |
| FL | 89 | 48.25% | 70.53% | 91.83% | 880.63 |
| GA | 91 | 59.61% | 74.00% | 89.07% | 1617.38 |
| HI | 47 | 77.35% | 88.06% | 97.45% | 1756.61 |
| IA | 59 | 62.09% | 77.26% | 92.74% | 1489.52 |
| ID | 60 | 62.45% | 81.79% | 94.38% | 1193.30 |
| IL | 102 | 63.31% | 75.08% | 90.26% | 2352.08 |
| IN | 68 | 80.08% | 89.85% | 97.10% | 2741.34 |
| KS | 59 | 51.84% | 74.07% | 95.60% | 1179.00 |
| KY | 65 | 47.29% | 66.37% | 89.69% | 832.28 |
| LA | 57 | 66.96% | 79.66% | 94.82% | 2244.54 |
| MA | 61 | 77.54% | 86.02% | 95.66% | 2532.94 |
| MD | 77 | 66.27% | 83.35% | 94.08% | 1666.04 |
| ME | 45 | 83.05% | 89.01% | 97.86% | 3774.34 |
| MI | 82 | 67.96% | 81.42% | 94.00% | 1392.33 |
| MN | 64 | 72.28% | 80.74% | 93.25% | 2890.99 |
| MO | 75 | 42.76% | 65.75% | 88.22% | 691.74 |
| MS | 61 | 60.98% | 76.81% | 95.31% | 1430.81 |
| MT | 52 | 57.21% | 80.00% | 95.89% | 1092.01 |
| NC | 75 | 62.82% | 75.76% | 91.27% | 1222.70 |
| ND | 43 | 81.88% | 91.97% | 99.05% | 3379.70 |
| NE | 51 | 57.61% | 77.62% | 95.11% | 1318.38 |
| NH | 49 | 59.78% | 80.99% | 96.59% | 1241.59 |
| NJ | 75 | 78.57% | 88.84% | 96.36% | 2807.09 |
| NM | 52 | 69.74% | 84.34% | 95.06% | 1530.53 |
| NV | 58 | 47.95% | 74.00% | 95.96% | 824.55 |
| NY | 73 | 83.29% | 90.51% | 97.03% | 3054.65 |
| OH | 92 | 63.56% | 77.49% | 92.08% | 1211.13 |
| OK | 60 | 81.37% | 90.67% | 97.02% | 2457.78 |
| OR | 66 | 70.72% | 82.95% | 93.86% | 1563.79 |
| PA | 95 | 41.73% | 63.82% | 87.39% | 639.06 |
| RI | 50 | 77.58% | 86.84% | 97.87% | 2378.59 |
| SC | 55 | 69.12% | 83.64% | 96.03% | 1463.31 |
| SD | 41 | 83.44% | 91.67% | 98.63% | 4338.19 |
| TN | 79 | 72.45% | 83.76% | 96.01% | 2072.47 |
| TX* | 99 | 46.57% | 63.59% | 85.01% | 774.31 |
| UT | 50 | 71.93% | 83.65% | 96.16% | 2666.53 |
| VA | 79 | 30.75% | 55.06% | 87.49% | 498.91 |
| VT | 46 | 73.03% | 89.96% | 98.29% | 1506.08 |
| WA | 77 | 59.73% | 78.15% | 93.04% | 1450.56 |
| WI | 59 | 73.45% | 83.87% | 96.04% | 1972.92 |
| WV | 62 | 72.58% | 89.48% | 97.02% | 1833.95 |
| WY | 40 | 86.43% | 93.56% | 99.16% | 2734.29 |

Source: National Association of Insurance Commissioners.

*Texas' largest medical liability insurer, the Texas Medical Liability Trust, is a statutorily created entity not reporting to the NAIC. If it is included into the calculations for Texas, the index increases to 1290.

 

Table 29 - Capital and Surplus Requirements, By State

[TO BE ADDED]

## Table 30 - Entries and Exits, Countrywide

| Year | Number of Insurers | Entries | Pct of Insurers* | Exits | Pct of Insurers* | Net Change | Pct of Insurers* |
|---|---|---|---|---|---|---|---|
| 1992 | 274 | 20 | 7.69% | 21 | 8.08% | -1 | (0.38%) |
| 1993 | 268 | 24 | 8.76% | 17 | 6.20% | 7 | 2.55% |
| 1994 | 278 | 14 | 5.22% | 13 | 4.85% | 1 | 0.37% |
| 1995 | 275 | 18 | 6.47% | 2 | 0.72% | 16 | 5.76% |
| 1996 | 281 | 10 | 3.64% | 10 | 3.64% | 0 | 0.00% |
| 1997 | 284 | 10 | 3.56% | 10 | 3.56% | 0 | 0.00% |
| 1998 | 277 | 8 | 2.82% | 10 | 3.52% | -2 | (0.70%) |
| 1999 | 275 | 11 | 3.97% | 11 | 3.97% | 0 | 0.00% |
| 2000 | 263 | 12 | 4.36% | 11 | 4.00% | 1 | 0.36% |
| 2001 | 252 | 10 | 3.80% | 18 | 6.84% | -8 | (3.04%) |
| 2002 | 258 | 15 | 5.95% | 17 | 6.75% | -2 | (0.79%) |

Source: National Association of Insurance Commissioners.

 

Table 31 - Median Insurer Entries and Exits, By State

| Year | Number of Insurers | Entries | Pct of Insurers* | Exits | Pct of Insurers* | Net Change | Pct of Insurers* |
|---|---|---|---|---|---|---|---|
| 1992 | 51 | 3 | 5.88% | 2 | 3.92% | 1 | 1.96% |
| 1993 | 53 | 4 | 7.84% | 3 | 5.88% | 1 | 1.96% |
| 1994 | 53 | 4 | 7.55% | 4 | 7.55% | 0 | 0.00% |
| 1995 | 58 | 4 | 7.55% | 2 | 3.77% | 2 | 3.77% |
| 1996 | 56 | 5 | 8.62% | 4 | 6.90% | 1 | 1.72% |
| 1997 | 61 | 4 | 7.14% | 3 | 5.36% | 1 | 1.79% |
| 1998 | 64 | 5 | 8.20% | 4 | 6.56% | 1 | 1.64% |
| 1999 | 65 | 5 | 7.81% | 6 | 9.38% | -1 | (1.56%) |
| 2000 | 61 | 6 | 9.23% | 5 | 7.69% | 1 | 1.54% |
| 2001 | 62 | 5 | 8.20% | 7 | 11.48% | -2 | (3.28%) |
| 2002 | 58 | 8 | 12.90% | 7 | 11.29% | 1 | 1.61% |

Source: National Association of Insurance Commissioners.

 

## Table 32 - 2002 Aggregate Premium By Company Type, By State

| State | Total | Stock | Mutual | Surplus & Excess | Reciprocal | Risk Retention Groups | Residual Mk. Mechanisms/ State Funds | Other |
|---|---|---|---|---|---|---|---|---|
| AK | 24,283,241 | 2,572,505 | 5,175,545 | 11,479,638 | 4,885,193 | 170,360 | . | . |
| AL | 153,648,074 | 29,830,966 | 88,298,826 | 16,489,502 | 17,340,261 | 1,688,519 | . | . |
| AR | 59,919,570 | 13,089,344 | 27,284,143 | 10,403,304 | 8,446,491 | 696,288 | . | . |
| AZ | 208,860,476 | 40,804,567 | 104,504,248 | 42,416,332 | 12,870,730 | 7,310,413 | . | 954,186 |
| CA | 800,628,603 | 260,628,511 | 199,574,631 | 136,894,411 | 178,836,528 | 20,173,303 | . | 4,521,219 |
| CO | 122,077,329 | 73,386,332 | 1,875,144 | 31,669,210 | 12,491,044 | 2,655,599 | . | . |
| CT | 163,449,319 | 46,225,362 | 42,265,180 | 28,893,402 | 10,524,149 | 33,359,408 | . | 2,181,818 |
| DC | 51,799,075 | 16,370,276 | 32,192 | 12,660,087 | 22,393,381 | 343,139 | . | . |
| DE | 26,456,426 | 20,293,872 | 865,650 | 3,685,978 | 847,825 | 763,101 | . | . |
| FL | 825,659,394 | 165,207,868 | 59,266,007 | 308,199,781 | 259,403,764 | 31,513,391 | . | 2,068,583 |
| GA | 322,113,305 | 72,378,637 | 128,591,388 | 88,008,319 | 15,315,248 | 5,188,156 | . | 12,631,557 |
| HI | 54,664,762 | 9,922,510 | 214,699 | 24,100,983 | 19,287,945 | 843,625 | . | 295,000 |
| IA | 94,542,725 | 58,921,552 | 4,190,737 | 26,827,511 | 2,007,019 | 2,595,906 | . | . |
| ID | 52,336,057 | 19,124,103 | 2,479,460 | 20,459,457 | 9,766,422 | 506,615 | . | . |
| IL | 562,660,857 | 152,456,615 | 4,826,038 | 122,091,019 | 271,418,524 | 11,007,054 | . | 861,607 |
| IN | 110,038,243 | 44,870,324 | 39,031,368 | 22,169,418 | 2,783,850 | 1,183,283 | . | . |
| KS | 85,220,699 | 33,335,608 | 22,294,344 | 19,470,647 | 8,232,047 | 746,299 | . | 1,141,754 |
| KY | 146,919,211 | 75,982,577 | 11,697,235 | 44,623,695 | 9,798,339 | 4,817,365 | . | . |
| LA | 110,443,020 | 28,263,114 | 43,245,808 | 36,717,826 | 967,535 | 1,248,737 | . | . |
| MA | 259,123,377 | 33,341,992 | 128,715,954 | 85,219,037 | 373,874 | 11,100,611 | . | 371,909 |
| MD | 227,510,540 | 69,167,768 | 71,258,290 | 35,253,225 | 7,656,357 | 43,375,331 | . | 799,569 |
| ME | 56,899,771 | 22,445,680 | 24,298,985 | 7,855,209 | 1,151,965 | 1,147,932 | . | . |
| MI | 247,842,638 | 140,092,678 | 1,314,131 | 81,221,103 | 15,349,195 | 9,765,067 | . | 100,464 |
| MN | 85,574,095 | 61,444,053 | 2,095,357 | 19,188,646 | 172,721 | 2,256,265 | . | 417,053 |
| MO | 204,395,602 | 78,578,449 | 25,729,706 | 33,247,270 | 60,747,185 | 3,436,419 | . | 2,656,573 |
| MS | 90,783,089 | 34,762,909 | 1,814,118 | 30,400,530 | 23,144,339 | 661,193 | . | . |
| MT | 50,350,396 | 25,496,310 | 226,138 | 18,951,428 | 5,422,598 | 243,492 | . | 10,430 |
| NC | 240,251,516 | 59,982,413 | 93,067,626 | 71,585,251 | 11,149,195 | 3,919,376 | . | 547,655 |
| ND | 35,622,802 | 23,929,659 | 204,311 | 10,835,754 | 544,052 | 109,026 | . | . |
| NE | 48,501,428 | 28,074,960 | 357,908 | 14,925,903 | 1,304,681 | 867,771 | . | 2,970,205 |
| NH | 43,462,049 | 10,641,738 | 13,685,494 | 17,818,007 | 425,607 | 891,203 | . | . |
| NJ | 442,871,124 | 300,064,340 | 2,526,484 | 126,394,018 | 920,875 | 5,660,036 | . | 7,305,371 |
| NM | 53,023,274 | 29,079,582 | 3,889,958 | 9,790,679 | 8,425,973 | 1,837,082 | . | . |
| NV | 99,487,744 | 50,120,881 | 10,507,153 | 26,941,061 | 9,782,579 | 2,136,070 | . | . |
| NY | 1,096,262,561 | 161,548,836 | 559,718,883 | 65,616,616 | 202,034,053 | 96,415,242 | . | 10,928,931 |
| OH | 484,411,830 | 271,852,346 | 90,771,019 | 79,935,711 | 34,000,257 | 7,567,189 | . | 285,308 |
| OK | 129,993,894 | 99,131,444 | 1,541,542 | 27,165,692 | 140,118 | 2,015,098 | . | . |
| OR | 109,305,884 | 38,622,212 | 24,947,070 | 32,100,431 | 11,449,997 | 2,186,174 | . | . |
| PA | 529,394,851 | 235,177,858 | 4,624,898 | 140,465,348 | 26,742,708 | 82,925,883 | 36,449,584 | 3,008,572 |
| RI | 44,693,360 | 19,751,063 | 15,603,504 | 7,601,217 | 127,782 | 1,609,794 | . | . |
| SC | 71,118,338 | 38,961,927 | 2,405,077 | 27,834,449 | 1,392,344 | 524,541 | . | . |
| SD | 36,769,475 | 23,312,569 | 691,079 | 11,987,511 | 654,543 | 123,773 | . | . |
| TN | 319,435,[illegible]2 | 61,874,864 | 124,503,686 | 92,979,845 | 37,619,045 | 2,438,026 | . | 19,976 |
| TX | 623,469,877 | 186,388,300 | 11,385,748 | 263,185,680 | 89,287,067 | 23,458,682 | 49,704,396 | 60,004 |
| UT | 75,643,008 | 42,794,517 | 1,500,756 | 27,324,688 | 3,492,204 | 530,843 | . | . |
| VA | 192,091,584 | 73,875,257 | 29,720,530 | 47,660,377 | 22,966,228 | 17,869,192 | . | . |
| VT | 36,658,782 | 15,905,342 | 5,270,314 | 13,314,240 | 590,765 | 305,394 | . | 1,272,727 |
| WA | 219,663,643 | 69,862,354 | 1,361,656 | 54,867,422 | 85,339,357 | 8,232,854 | . | . |
| WI | 105,789,801 | 77,148,165 | 1,813,395 | 22,060,851 | 414,543 | 2,243,191 | 2,047,168 | 62,488 |
| WV | 103,966,758 | 71,383,838 | 920,108 | 29,097,294 | 1,280,379 | 1,285,139 | . | . |
| WY | 38,257,260 | 19,423,132 | 106,538 | 13,494,815 | 5,092,611 | 140,164 | . | . |
| CW | 10,378,346,179 | 3,637,902,079 | 2,042,290,059 | 2,553,579,828 | 1,536,811,492 | 464,088,614 | 88,201,148 | 55,472,959 |

Source: National Association of Insurance Commissioners.

## Table 33 - 2002 Percent of Market Share By Company Type, By State

| State | Total Direct Written Premium | Stock % | Mutual % | Surplus Lines % | Reciprocal % | Risk Retention Group % | Residual Market Mechanism % | Other % |
|---|---|---|---|---|---|---|---|---|
| AK | 24,283,241 | 10.59% | 21.31% | 47.27% | 20.12% | 0.70% | - | - |
| AL | 153,646,074 | 19.42% | 57.47% | 10.73% | 11.29% | 1.10% | . | . |
| AR | 59,919,570 | 21.84% | 45.53% | 17.36% | 14.10% | 1.16% | . | . |
| AZ | 208,860,476 | 19.54% | 50.04% | 20.31% | 6.16% | 3.50% | . | 0.46% |
| CA | 800,628,603 | 32.55% | 24.93% | 17.10% | 22.34% | 2.52% | . | 0.56% |
| CO | 122,077,329 | 60.11% | 1.54% | 25.94% | 10.23% | 2.18% | . | . |
| CT | 163,449,319 | 28.28% | 25.86% | 17.68% | 6.44% | 20.41% | . | 1.33% |
| DC | 51,799,075 | 31.60% | 0.06% | 24.44% | 43.23% | 0.66% | . | . |
| DE | 26,456,426 | 76.71% | 3.27% | 13.93% | 3.20% | 2.88% | . | . |
| FL | 825,659,394 | 20.01% | 7.18% | 37.33% | 31.42% | 3.82% | . | 0.25% |
| GA | 322,113,505 | 22.47% | 39.92% | 27.32% | 4.75% | 1.61% | . | 3.92% |
| HI | 54,664,762 | 18.15% | 0.39% | 44.09% | 35.28% | 1.54% | . | 0.54% |
| IA | 94,542,725 | 62.32% | 4.43% | 28.38% | 2.12% | 2.75% | . | . |
| ID | 52,536,057 | 36.54% | 4.74% | 39.09% | 18.66% | 0.97% | . | . |
| IL | 562,660,857 | 27.10% | 0.86% | 21.70% | 48.24% | 1.96% | . | 0.15% |
| IN | 110,038,243 | 40.78% | 35.47% | 20.15% | 2.53% | 1.08% | . | . |
| KS | 85,220,699 | 39.12% | 26.16% | 22.85% | 9.66% | 0.88% | . | 1.34% |
| KY | 146,919,211 | 51.72% | 7.96% | 30.37% | 6.67% | 3.28% | . | . |
| LA | 110,443,020 | 25.59% | 39.16% | 33.25% | 0.86% | 1.13% | . | . |
| MA | 259,123,377 | 12.87% | 49.67% | 32.89% | 0.14% | 4.28% | . | 0.14% |
| MD | 227,510,540 | 30.40% | 31.32% | 15.50% | 3.37% | 19.07% | . | 0.35% |
| ME | 56,899,771 | 39.45% | 42.70% | 13.81% | 2.02% | 2.02% | . | . |
| MI | 247,842,638 | 56.52% | 0.53% | 32.77% | 6.19% | 3.94% | . | 0.04% |
| MN | 85,574,095 | 71.80% | 2.45% | 22.42% | 0.20% | 2.64% | . | 0.49% |
| MO | 204,395,602 | 38.44% | 12.59% | 16.27% | 29.72% | 1.68% | . | 1.30% |
| MS | 90,783,089 | 38.29% | 2.00% | 33.49% | 25.49% | 0.73% | . | . |
| MT | 50,350,396 | 50.64% | 0.45% | 37.64% | 10.77% | 0.48% | . | 0.02% |
| NC | 240,251,516 | 24.97% | 38.74% | 29.80% | 4.64% | 1.63% | . | 0.23% |
| ND | 35,622,802 | 67.18% | 0.57% | 30.42% | 1.53% | 0.31% | . | . |
| NE | 48,501,428 | 57.88% | 0.74% | 30.77% | 2.69% | 1.79% | . | 6.12% |
| NH | 43,462,049 | 24.49% | 31.49% | 41.00% | 0.98% | 2.05% | . | . |
| NJ | 442,871,124 | 67.75% | 0.[illegible]% | 28.54% | 0.21% | 1.28% | . | 1.65% |
| NM | 53,023,274 | 54.84% | [illegible] | 18.46% | 15.89% | 3.46% | . | . |
| NV | 99,487,744 | 50.38% | 10.56% | 27.08% | 9.83% | 2.15% | . | . |
| NY | 1,096,262,561 | 14.74% | 51.06% | 5.99% | 18.43% | 8.79% | . | 1.00% |
| OH | 484,411,830 | 56.12% | 18.74% | 16.50% | 7.02% | 1.56% | . | 0.06% |
| OK | 129,993,894 | 76.26% | 1.19% | 20.90% | 0.11% | 1.55% | . | . |
| OR | 109,305,884 | 35.33% | 22.82% | 29.37% | 10.48% | 2.00% | . | . |
| PA | 529,394,851 | 44.42% | 0.87% | 26.53% | 5.05% | 15.66% | 6.89% | 0.57% |
| RI | 44,693,360 | 44.19% | 34.91% | 17.01% | 0.29% | 3.60% | . | . |
| SC | 71,118,338 | 54.78% | 3.38% | 39.14% | 1.96% | 0.74% | . | . |
| SD | 36,769,475 | 63.40% | 1.88% | 32.60% | 1.78% | 0.34% | . | . |
| TN | 319,435,442 | 19.37% | 38.98% | 29.11% | 11.78% | 0.76% | . | 0.01% |
| TX | 623,469,877 | 29.90% | 1.83% | 42.21% | 14.32% | 3.76% | 7.97% | 0.01% |
| UT | 75,643,008 | 56.57% | 1.98% | 36.12% | 4.62% | 0.70% | . | . |
| VA | 192,091,584 | 38.46% | 15.47% | 24.81% | 11.96% | 9.30% | . | . |
| VT | 36,658,782 | 43.39% | 14.38% | 36.32% | 1.61% | 0.83% | . | 3.47% |
| WA | 219,663,643 | 31.80% | 0.62% | 24.98% | 38.85% | 3.75% | . | . |
| WI | 105,789,801 | 72.93% | 1.71% | 20.85% | 0.39% | 2.12% | 1.94% | 0.06% |
| WV | 103,966,758 | 68.66% | 0.89% | 27.99% | 1.23% | 1.24% | . | . |
| WY | 38,257,260 | 50.77% | 0.28% | 35.27% | 13.31% | 0.37% | . | . |
| CW | 10,378,346,179 | 35.05% | 19.68% | 24.60% | 14.81% | 4.47% | 0.85% | 0.53% |

Source: National Association of Insurance Commissioners.

 

Table 34 - Analysis of Risk-Based Capital Action Levels, Countrywide

| Year | No Action Taken | Company Action Level | Regulatory Action Level | Authorized Control Level | Mandatory Control Level |
|---|---|---|---|---|---|
| 1994 | 253 | 7 | 3 | . | 6 |
| 1995 | 251 | 4 | 4 | 1 | 6 |
| 1996 | 255 | 7 | 3 | 1 | 6 |
| 1997 | 264 | 6 | 1 | 1 | 5 |
| 1998 | 252 | 4 | 2 | 1 | 5 |
| 1999 | 236 | 4 | . | 2 | 5 |
| 2000 | 225 | 7 | 1 | 1 | 5 |
| 2001 | 230 | 3 | 4 | 1 | 9 |
| 2002 | 237 | 3 | 4 | 2 | 8 |

Source: National Association of Insurance Commissioners.

 

## Table 35 - Non-Economic Damage Caps, By State

| STATE | CITATION | DESCPRIPTION | JUDCIAL DECISON |
|---|---|---|---|
| AL | § 6-5-544 | In 1987, Alabama enacted a statewide medical malpractice cap. The statute, which has never been repealed, provides that a medical malpractice plaintiff's recovery for non-economic losses, including punitive damages, cannot exceed $400,000. | The Alabama Supreme Court declared this statute to be unconstitutional in Moore v. Mobile Infirmity Ass'n, 592 So. 2d 156 (Ala. 1991). |
| AK | § 09.17.010 | Damages awarded by a court, arising out of a single injury or death cannot exceed $400,000 or the injured person's life expectancy in years multiplied by $8,000,whichever is greater. The upper-tier cap for severe disfigurement or physical impairment, the greater of $1,000,000 or the plaintiff's life expectancy, in years, multiplied by $25,000 The amended statute also clarifies that multiple injuries arising out of one incident invoke only one cap, and that consortium claims do not open up a second cap. | |
| AZ | None | Arizona does not place a cap on the amount of damages recoverable in a medical malpractice action. Article 2, § 31 of the Arizona constitution prohibits the enactment of any law limiting the damages one may recover for personal injury or death. | |
| AR | None | No medical malpractice caps. | |
| CA | Civ § 3333.2 | The amount of damages for non-economic losses cannot exceed $250,000. | The cap on non-economic damages was held to be constitutional in Fein v. Permanente Medical Group, 38 Cal. 3d 137, 695 P.2d 665, 211 Cal. Rptr. 368 (1985). See also Yates v. Pollock, 194 Cal. App. 3d 195, 239 Cal. Rptr. 383 (1987) and Atkins v. Strayhorn, 223 Cal. App. 3d 1380, 273 Cal. Rptr. 231 (1990) |
| CO | § 13-64-302 | Damages for medical malpractice against a hospital or physician may not exceed $1,000,000 per patient, including any derivative claim by any other claimant. Of that $1,000,000, not more than $250,000 may be attributable to non-economic loss or injury. However, if the court finds that the future economic damages exceed this cap, it may award damages in excess of the limit. | This damage cap was held to be constitutional in Scholz v. Metropolitan Pathologists, P.C., 851 P.2d 901 (Colo. 1993). |
| CT | None | No medical malpractice caps. | |
| DE | None | No medical malpractice caps. | |
| DC | None | No medical malpractice caps. | |
| FL | §§ 766.207, 766.209 | There is no cap unless voluntary binding arbitration is used to make a determination of damages. If a defendant refuses to accept the claimant's offer to arbitrate, the claimant, if successful at trial, is entitled to pre-judgment interest and up to 25 percent of the award in attorneys' fees. If a claimant refuses to accept a defendant's offer to arbitrate, his recovery will be limited to economic damages (but only 80 percent of lost wages) plus no more than $350,000 in non-economic damages. If the claimant does accept, his recovery will be limited to economic damage (but only 80 percent of lost wages) plus no more than $250,000 in non-economic damages, plus attorneys' fees of fifteen percent. | This damage cap was held to be constitutional in University of Miami v. Echarte, 618 So. 2d 189 (Fla.), cert. denied, 510 U.S. 915 (1993). |
| GA | § 51-12-5.1 | Georgia does not place a cap on the amount of compensatory damages that may be awarded. However, punitive damages are capped at $250,000, unless the claimant can successfully demonstrate that the defendant had an intent to harm | |
| HI | §§ 663-8.5, 663-8.7, 671-15 | Non-economic damages that are recoverable in tort actions include damages for pain and suffering, mental anguish, loss of enjoyment of life, loss of consortium, and all other non-pecuniary losses or claims. The amount of damages recoverable for pain and suffering cannot exceed $375,000. | |

 

| | | | |
|---|---|---|---|
| ID | § 6-1603 | Non-economic damages for personal injury or wrongful death cannot exceed $400,000. The $400,000 cap has been adjusted on July 1 of each year since 1988 by the rate of increase in average wages in Idaho. The limitation on non-economic damage awards is inapplicable to causes of action arising out of willful or reckless conduct and to causes of action arising out of acts constituting a felony under state or federal law. | |
| IL | 735 Ill. Comp. Stat. Ann. § 5/2-1115.1 | In 1995, the Illinois legislature passed a $500,000 limit on non-economic damages in medical malpractice cases. | The medical malpractice cap was declared unconstitutional in Best v. Taylor Machine Works, 179 Ill. 2d 367, 689 N.E.2d 1057 (1997 |
| IN | § 34-18-14-3 | A health care provider is not liable for an amount in excess of $250,000 for an occurrence of malpractice. Damages for all providers cannot exceed $1,250,000 per occurrence of malpractice. | The cap was held to be constitutional in Johnson v. St. Vincent Hospital, 273 Ind. 374, 394-401, 404 N.E.2d 585, 598-602 (1980). |
| IA | None | No medical malpractice caps. | |
| KS | None | In 1986, Kansas enacted a statewide medical malpractice cap. | The medical malpractice cap was declared unconstitutional in Kansas Malpractice Victims Coalition v. Bell, 243 Kan. 333, 757 P.2d 251 (1988). |
| KY | None | No medical malpractice caps. | |
| LA | §§ 40:1299:42, 40:1299:44 | The Louisiana Medical Malpractice Act established a Patient's Compensation Fund. State health care providers are automatically entitled to be covered by the fund. Private health care providers may join the fund if they file proof that they are covered by a policy of malpractice liability insurance in an amount of at least $100,000 per claim and pay the surcharge assessed by the Louisiana Insurance Rating Commission. The liability of each qualified health care provider is limited to $100,000 plus interest per patient per incident. Judgments, settlements, or binding arbitration orders in excess of $100,000 per provider are paid out of the fund. The claimant's total recovery is limited to $500,000 plus future medical costs. | The Louisiana Supreme Court has held that the limit on damages of $500,000 plus future medical costs is constitutional. Butler v. Flint Goodrich Hospital of Dillard University, 607 So. 2d 517 (La. 1992), cert. denied, 508 U.S. 909 (1993). |
| ME | None | No medical malpractice caps. | |
| MD | Cts. & Jud. Proc. § 11-108 | The limit on recoverable non-economic damages for any personal injury cause of action for medical malpractice cannot exceed $500,000. Beginning October 1, 1995, and every October 1 thereafter, the limit on non-economic damages is increased by $15,000. | |
| MA | § 231: 60H | In any action for malpractice, the court may not award the plaintiff more than $500,000 for pain and suffering, loss of companionship, embarrassment and other items of general damages. | |
| MI | §§ 600.1483, 600.6304 | The total amount of damages for non-economic loss recoverable by all plaintiffs cannot exceed $280,000. Exceptions allow the court, in some circumstances, to maximize damages to no more than $500,000. The court will reduce a jury award in excess of this amount. | |
| MN | None | No medical malpractice caps. | |
| MS | § 85-5-7 | The limit for non-economic damages cannot exceed $500,000 if the claim was filed after passage of House Bill No. 2, but before 07/01/2011. Any claim filed on or after 07/01/2011, but before 07/01/2017, the amount of non-economic damages cannot exceed $750,000. For claims on or after 07/01/2017, the amount of non-economic damages cannot exceed $1,000,000. | |
| MO | § 538.210 See also Missouri HB 273 | In 1986, the Missouri General Assembly enacted a $350,000 per occurrence limit for non-economic damages. This limit is subject to annual adjustments by the Director of the Division of Insurance to reflect increases in the consumer price index. In 2003, the Director of Insurance set the limit for non-economic damages at $557,000. | The medical malpractice cap was declared constitutional in Adams v. Children's Mercy Hospital, 832 S.W.2d 898 (Mo.), cert. denied, 506 U.S. 991 (1992). |
| MT | § 25-9-411 | In a malpractice claim or claim against one or more health care providers based on a single incident of malpractice, an award for past and future damages for non-economic loss cannot exceed $250,000. | |

 

| | | | |
|---|---|---|---|
| NE | § 44-2825 | A health care provider is not liable to any patient or his or her representative for an amount in excess of $200,000. The total amount recoverable under the Nebraska Hospital-Medical Liability Act from any and all health care providers cannot exceed $1.25 million, for any occurrence after 12/31/92. No specific cap for non-economic damages. | |
| NV | § 41A.031 | The non-economic damages awarded for medical malpractice or dental malpractice cannot exceed $350,000. This amount can vary with an exemption for certain conditions. Exemptions to the stated limit must not exceed the amount of money remaining under a professional liability insurance policy limit covering the defendant after subtracting the economic damages awarded to that plaintiff. This limitation does not apply to damages for medical malpractice unless the defendant was covered by professional liability insurance at the time of the occurrence and on the date the insurer receives notice of the claim. | |
| NH | §§ 507-C:7, 508:4-d | In 1986, New Hampshire enacted a medical malpractice cap that limited total damages to $875,000. | On two occasions, the New Hampshire Supreme Court declared the medical malpractice cap unconstitutional in Carson v. Maurer, 120 N.H. 925, 424 A.2d 825 (1980) and Brannigan v. Usitalso, 134 N.H. 50, 587 A.2d 1232 (1991). |
| NJ | New Jersey Medical Malpractice Bills<br>A3080<br>A2931<br>S2035 | A $250,000 cap would limit non-economic damages, unless the plaintiff is "hemiplegic, paraplegic, or quadriplegic, the plaintiff has permanently impaired cognitive capacity rendering him incapable of independent daily living, or there has been a permanent loss of or damage to a reproductive organ resulting in the inability to procreate." In those cases the cap would be $500,000. | |
| NM | § 41-5-6 | Except for punitive damages and medical care and related benefits, the amount recoverable from any injury or death as a result of malpractice cannot exceed $600,000 per occurrence. | |
| NY | None | No medical malpractice cap. | |
| NC | None | No medical malpractice cap. | |
| ND | § 32-42-02 | For claims arising after April 1, 1995, there is a $500,000 cap on non-economic damages in medical malpractice cases. This applies regardless of the number of defendants, the number of theories, or the number of family members who sue. | |
| OH | Ohio Senate Bill 281<br>Effective 04/11/03 | The cap on non-economic damages is limited to the greater of $250,000 or an amount equal to 3 times the plaintiff's economic loss up to a maximum of $500,000. Non-economic losses for permanent and substantial physical deformity are limited to the greater of $1 million or an amount equal to $15,000 times the number years remaining in the plaintiff's expected life. | |
| OK | None | No medical malpractice cap. | |
| OR | § 18.560 | In 1987, the Oregon legislature established a $500,000 cap on damages for non-economic loss in bodily injury and death cases. | The Oregon Supreme Court ruled it to be unconstitutional under most circumstances. It held that the damage cap violates the right to a jury trial provided by the state constitution whenever the cap is applied to a claim. Lakin v. Senco Products, Inc., 329 Or. 62, 987 P.2 463, 1999 WL 498088 (July 15, 1999). |
| PA | Act 13 - HB 1802<br>Approved by Gov.<br>03/20/02 | The liability limit of the Medical Liability Catastrophe Loss Fund for each healthcare provider that conducts more than 50% of its healthcare business in Pennsylvania and for each hospital cannot exceed $700,000 per occurrence and $2.1 million per aggregate. For each participating healthcare provider, the limit of liability cannot exceed $500,000 per occurrence and $1.5 million per aggregate. | |
| RI | None | No medical malpractice cap. | |
| SC | None | No medical malpractice cap. | |

 

| | | | |
|---|---|---|---|
| SD | § 21-3-11 | In any medical malpractice action in South Dakota, the total general damages cannot exceed $500,000. | This statute formerly provided for a cap of $1,000,000 on all damages, whether economic or non-economic. The cap on all damages, however, was found to violate the state constitution. Knowles v. U.S., 544 N.W.2d 183 (S.D. 1996). The Knowles decision automatically revived the form of the statute, as it existed prior to being amended in 1985, at which time it provided for a $500,000 cap on general damages. |
| TN | None | No medical malpractice cap. | |
| TX | Tex. Rev. Civ. Stat. Ann. art. 4590i, §§ 11.02, 11.04 | Texas law limits damages in a medical malpractice action for wrongful death to $500,000 (in 1977 dollars). This amount is adjusted annually for inflation, and is now approximately $1,300,000. | The statute was intended to apply to all medical malpractice cases, but has been held to be unconstitutional except with respect to wrongful death. Rose v. Doctors Hospital, 801 S.W.2d 841 (Tex. 1990). |
| UT | § 78-14-7.1 | In a medical malpractice action, non-economic damages cannot exceed $250,000. When indexed for inflation, the limit is $400,000. | |
| VT | None | No medical malpractice cap. | |
| VA | § 8.01-581.15 | Virginia imposes a $1,500,000 damage cap on recoveries for bodily injury or death in medical malpractice cases occurring after August 1999. Each year the cap is increased by $50,000 annually. | |
| WA | § 4.56.250 | In 1986, Washington enacted a statewide medical malpractice cap. | The Supreme Court of Washington held that the statutory cap on non-economic damages is an unconstitutional infringement of the right to trial by jury. Sofie v. Fireboard Corp., 112 Wash. 2d 636, 771 P.2d 711 (1989). |
| WV | § 55-7B-8 | In 1986, West Virginia enacted a statewide medical malpractice cap. In West Virginia the jury is instructed that the maximum it may award against a health care provider for non-economic loss is $1,000,000. | The medical malpractice cap was declared to be constitutional in Robinson v. Charleston Area Medical Center, 186 W. Va. 720, 414 S.E.2d 877 (1991). |
| WI | § 893.55 | Except in death cases, for any medical malpractice occurrence on or after May 25, 1995, the total limit on non-economic damages from all health care providers is $350,000. This limit is adjusted annually for inflation. | |
| WY | None | No medical malpractice cap. | |

Source: National Association of Insurance Commissioners.

 

Table 36 - States That Have Enacted Patient Compensation Funds
Medical Liability Insurance

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HARD COPY SENT VIA REGULAR MAIL

January 22, 2004

Commissioner Jose Montemayor
Chair, Market Conditions Working Group
c/o Eric Nordman, CPCU, CIE
National Association of Insurance Commissioners
2301 McGee Street, Suite 800
Kansas City, MO 64108-2662

**Re: Comments on December 3, 2003 draft of "Medical Malpractice Insurance: A Study of Market Conditions"**

Dear Commissioner Montemayor:

On behalf of the American Medical Association (AMA) I am writing to provide the following comments regarding the National Association of Insurance Commissioners' Market Conditions Working Group draft report "Medical Malpractice Insurance: A Study of Market Conditions" (December 3, 2003).

The AMA applauds the Working Group for its time and effort in studying the medical liability insurance market and in preparing this report. As the national organization for insurance regulators the NAIC plays an extremely important role in this issue and it is likely this report will be an integral part of any policy discussions on medical liability reform at the state and federal level.

While this draft of the report is a good effort to deal with a complicated subject rife with conflicting opinion, as the working group continues to develop its report and study the issue, the AMA would like to offer the following suggestions to refine the report. First, medical liability reform has been the subject of an enormous amount of literature and studies written from various perspectives and motivated by widely differing agendas. As one would expect, the quality of information available on medical liability reform can vary dramatically. As the working group continues to develop its report, the AMA would encourage the group to base the report's text and recommendations on peer-reviewed economic studies firmly grounded in empirical data. Opinion-based position papers and law review articles certainly have their role in the reform debate. The AMA suggests, however, that since the basis of the report is NAIC's own economic analysis of the medical liability market, reference to position papers and law review articles to support economic theories in the "tort reform" section is misleading, particularly since it appears to give them equal weight as peer reviewed economic studies. The AMA also believes the reader would benefit from the clarification of various legal theories throughout the report and a review of the organization of the report. For example, it may benefit the reader's understanding of the various tort reforms discussed if the literature supporting these reforms is separated from the literature opposing these reforms. Finally, the AMA urges the working group to accurately state AMA's strong policy on medical liability reform in the report.

Following are the AMA's specific comments based on these concerns.

**The Public Hearing on Medical Malpractice**
(pg. 19) At the public hearing on medical liability reform, the AMA provided a handout to attendees titled "Medical Liability Reform Now." Like the slides used by Dr. Anderson and Jay Angoff, the AMA requests that the NAIC make this handout available on request. An electronic version of the document is attached for your convenience.

**Market Analyses from Other Studies**
(pg. 22) In summarizing the American Medical Association's Health Care Financial Trends Report, the factors that have driven the trend in claims severity are misstated. The Trends Report found that the "overall upward trend in premiums is attributable to the trends in claims severity and the factors that drive those trends include increases in jury awards, settlements, and the frequency of million dollar verdicts." To ensure accuracy, the AMA respectfully requests that the NAIC clarify the report based on the above.

**Review of Medical Malpractice Insurance Market, 1992-2002**
The major concern with this section of the report is the product market definition for medical malpractice insurance. The report provides the following implicit definition of the market: "For purposes of this report, medical liability will encompass insurance purchased by health care providers, hospitals, nursing homes and other institutions that provide health services."

There is a caveat later in the section (see page 48), "The data contains many insurers, often captive insurers that do not actively write insurance in the market. Captive insurers may write insurance for a specific group of hospitals, nursing homes or medical specialties and hence do not directly compete for market share. The data also includes insurers that may write insurance exclusively in certain markets, such as hospitals or certain medical specialties." This should be stated earlier to warn the reader that the discussion on concentration that follows uses this aggregate market definition.

While it would be difficult to apply a purely economic rule for defining the product markets, medical liability insurance for physicians and for hospitals are distinct products. If NAIC has data on direct written premiums by product line, it should be presented. Otherwise, the Herfindahl-Hirschman Indexes (HHIs) for two states that are derived from the sum of direct written premiums over these and other medical liability insurance products could be nearly equal, but the value of one may be driven by the existence of one or two large hospital insurers and the other by a few large physician insurers.

Following are specific concerns and questions regarding the data provided in this section:

In the discussion of mean insurer direct premiums and median insurer direct premium written, it is noted that "... differences between the mean and median values are important to examine in the context of market concentration. Markets tend to be more competitive when the mean and median are similar in relative terms." A comparison of the mean and median insurer written premiums does not provide information about the tails of the distribution. Is there a theoretical or empirical basis for using this difference as a measure of market concentration? How does this difference measure relate to the HHI?

The changes in the number of insurers accounts for mergers, new entries, and exits for various reasons. While the Department of Justice criteria for evaluating mergers based on the HHI (and increases in the HHI post-merger) can be used as a benchmark in evaluating market concentration in medical liability insurance markets, the repeated mention of merger guidelines, proposed horizontal merger, and post-merger markets may leave the reader with the notion that changes in

the number of insurers was a result of merger activity. Given the report provides no data on the number or size of mergers, the merger activity terminology should be used more sparingly.

Are the numbers of insurers in the tables on market concentration and premiums (e.g., Table 26 and Table 27) the count of insurers with direct written premiums, or do they include insurers who are licensed, but not providing coverage? Likewise, do the mean premium written and median premium written figures include only insurers with direct written premiums? In the introduction to this section and in the discussion of losses (see footnotes 36 and 37) there are slightly different definitions of "insurer."

In the discussion of the HHI, number of insurers and the size of state population, in Table 26 and Table 27, it is stated that "there is an approximately inverse correlation between the numbers of insurers writing premium in a market with the concentration of business they write." and "It also appears, from the data, that states with smaller populations have a more concentrated market than states with larger populations." What are the correlations between these variables?

The discussion in the section "Entry and Exit Conditions" confuses the cost of doing business with barriers that new insurers face in entering a market that established firms either did not face upon entry, or do not currently face.

- For example"...there must be at least a dollar of surplus for every dollar of premium volume a new insurer intends to write. This raises the financial requirement considerably for a new insurer intending to acquire a significant market share in a large state." But an incumbent insurer also needs a surplus to expand.

- There is reference to "non-monetary barriers" which are actually monetary cost, not barriers to entry: "In addition, there are non-monetary barriers to entering the medical malpractice market." The list that follows leads the reader to believe that these are barriers to entry that incumbent insurers impose on new entrants. In most cases these "non-monetary barriers" are costs of doing business. They generally do not differ between incumbents and new insurers (e.g., regulatory constraint). If they do differ and result in a short-term differential cost advantage, it is not a barrier to entry (e.g., lack of specialty market experience and lack of locally knowledgeable staff).

**Survey of Market Interventions**

*Tort Reform*

The AMA believes the current medical liability crisis which is threatening access to health care in 19 states is driven by increases in jury awards, which jumped 176 percent from 1994 to 2001, with the median jury award now topping $1 million. These sharp increases have in turn increased premiums for medical liability insurance. To stabilize the market, the legal system must be reformed and the only proven reform is California's Medical Injury and Compensation Reform Act or MICRA, which has proven effective for almost thirty years in stabilizing the medical liability market in California. The cornerstone of MICRA and a key element for any medical liability reform package is a reasonable cap on non-economic damages. Following are our specific comments on the various elements of tort reform discussed in the report.

(pg. 61) The report cites the AMA's Health Care Financial Trends Report on medical professional liability insurance as stating that the AMA offers three policy options on tort reforms. In fact, the Trends Report "highlights" these as policy options. We believe this reference minimizes the AMA's strong policy on medical liability reform as adopted by the AMA's House of Delegates.

It is the policy of the AMA that effective medical liability reform must be based on the California Medical Injury and Compensation Reform Act (MICRA) model, including a $250,000 cap on non-economic damages, offset of collateral sources of plaintiff compensation, decreasing incremental or sliding scale attorney contingency fees, periodic payment of future damages, and limiting the time period for suspending a minor's statute of limitations to no more than six years after birth. (H-435.967) For the working group's convenience, a copy of the AMA's policy is attached. **The AMA respectfully requests that our policy is accurately stated in the report.**

(pg. 61) The AMA cautions the NAIC against citing Hunter and Doroshow's article *Premium Deceit* because this article relies on flawed analysis to support their conclusions. For example, to gauge the average premium paid by physicians in California versus other states, the authors used flawed methodology by including premiums paid by all types of health care providers, not just physicians, in the numerator, and overstating the number of physicians who purchase medical liability insurance by including retired physicians, physicians who teach, physicians who conduct research, and physicians in the military – all of whom do not purchase medical liability insurance – in the denominator. Using NAIC's own data, it's clear that since 1976 medical liability premiums in California have grown slower (182%) than the rest of the nation (569%).

(pg. 63) While the NAIC draft report summarized the conclusions of the 1986 GAO Report, *Medical Malpractice: Six State Case Studies Show Claims and Insurance Costs Still Rise Despite Reforms*, finding that some states found their reforms had been effective while other states did not, the NAIC report does not specify which states fell into the two categories – a critical point to understanding effective reforms. The GAO report stated that reforms enacted in California and Indiana had helped to moderate upward trends in the cost of insurance and the average amount paid per claim, while those in Arkansas, Florida, New York and North Carolina had little effect. This distinction is critical since California and Indiana were the only states of the six that enacted **effective** caps on damages as part of their package of medical liability reforms. To enhance the accuracy of the report, the AMA encourages the NAIC to provide this detail in their report.

*Damage Limitations, Caps*

A reasonable cap on non-economic damages is the single most important element of any liability reform package. At least 20 states have laws that limit awards for non-economic damages in medical liability causes of action. Another six states cap total damages. The amount and structure of the cap varies dramatically among the states. For example, some states place a hard cap on non-economic damages, while others have a cap that is subject to exceptions for certain types of injuries or increases annually for inflation. **The AMA encourages the NAIC to include these distinctions in this section of the report because as the structure of the cap varies among the states, so does its effectiveness. We believe the available empirical evidence shows that only a $250,000 hard cap on non-economic damages – like California's that is neither subject to exceptions or inflationary increases – is effective in controlling medical liability premiums.**

The effectiveness of a reasonable cap on non-economic damages is further confirmed by studies published in peer-reviewed journals and research conducted by various governmental agencies, which show that caps are effective in reducing claims payments, stabilizing medical liability premiums, reducing overall health care costs, and ensuring patients have access to health care. These sources of information offer the best evidence that caps work because they consider, and rule out, other competing explanations. While some of these studies are mentioned in the report, the report does not include references to some of the leading peer reviewed studies on the effectiveness of caps on damages. For example, the report does not include a reference to Kessler

and McClellan's 1997 study, which found that direct reforms (which include caps on non-economic damages) reduced the likelihood that a physician will be sued by 2.1% and within three years reduced premiums by 8.4% compared to states without direct reforms. *Kessler, Daniel P. and Mark. B. McClellan. "The Effects of Malpractice Pressure and Liability Reforms on Physicians' Perceptions of Medical Care." Law and Contemporary Problems 60 (Winter 1997): 81-106.* While the NAIC report cites one study by Sloan, it does not reference another Sloan study which after examining a large set of closed claims, found that caps on non-economic damages reduced insurer payouts by 31% and reduced payouts-plus-expenses by 23%. *Sloan, Frank A., Paul M. Mergenhagen, and Randall R. Bovbjerg. "Effects of Tort Reforms on the Value of Closed Medical Malpractice Claims: a Microanalysis." Journal of Health Politics, Policy and Law 14 (Winter 1989): 663-66?* Finally, looking at the impact of MICRA style reforms specifically, LECG, Inc. concluded that caps on non-economic damages had reduced the average size of large malpractice claims, though average claim size had increased. In addition, the data examined suggested that MICRA had not inhibited the filing of claims (claim frequency was substantially unchanged). *LECG, Inc, "California's MICRA Reforms: How Would a Higher Cap on Non-Economic Damages Affect the Cost and Access to Health Care?" Fall 1998.* The AMA recommends that the NAIC include these leading studies in the report. The AMA also strongly encourages the working group to include a recommendation in the final report supporting a reasonable cap on non-economic damages as the single most important element of a medical liability reform package.

To strengthen this section of the report, the AMA offers the following specific comments on the "Damage Limitations, Caps" section:

(pg. 9, 65, 74, 80) Throughout the report references are made regarding damages awarded to compensate individuals for medical error. Damages are awarded in a medical liability cause of action based on a finding of medical *negligence* not medical *error*. A defendant is liable for negligence in a medical liability cause of action when conduct falling below the applicable standard of care is found to have caused the plaintiff's injury.

(pg. 65) The NAIC report inaccurately states that punitive damages are included in some cases as part of an award for non-economic damages. Punitive damages are awarded separately from non-economic damages and are based on a different legal standard. Unlike non-economic damages, punitive damages are generally awarded where the defendant is found to have *intentionally* inflicted harm on the patient or acted with gross negligence. The purpose of awarding punitive damages is to punish the defendant. By contrast, non-economic damages are awarded to compensate the plaintiff.

(pg. 65) The AMA offers the following suggestions to Table 35. We believe these changes are necessary to ensure the chart has the most recent information and to accurately distinguish between the various state laws limiting non-economic damages.

> Florida – In 2003 the Florida legislature enacted a new cap on non-economic damages. The cap provision in the chart should be replaced with the following information:
> For physicians $500,000 cap on non-economic damages per claimant with any one physician not responsible for more than $500,000. For nonpractitioners, $750,000 cap on non-economic damages. The cap increases to $1 million in non-economic damages for physicians if (1) the negligence resulted in death or a permanent vegetative state, or (2) if the court finds that a manifest injustice would occur unless the non-economic

damages cap was increased because the non-economic harm sustained by the patient was particularly severe and the defendant's negligence caused a *catastrophic injury* to the patient.

Idaho –In 2003 the legislature enacted a new cap on non-economic damages. The cap provision in the chart should be replaced with the following information:
$250,000 cap on non-economic damages per claimant in personal injury and wrongful death actions. (Idaho had a previous $400,000 cap that was adjusted annually since 1988).
The cap will be adjusted annually beginning July 1, 2004 based on the average annual wage.
The limit does not apply to causes of action arising out of willful or reckless misconduct, or felonious actions.

Previous cap upheld as constitutional in *Kirkland v. Blaine County Medical Center,* 134 Idaho 464, 4 P.3d 115 (Idaho, 2000).

Indiana – Any amount awarded over $250,000 will be paid through the patient compensation fund. For consistency, the drafters may consider including the same explanation of the patient compensation fund as provided in Louisiana's description.

Kansas – Subsequent to the *Kansas Malpractice Victims* case, Kansas' legislature enacted a $250,000 cap on non-economic damages recoverable by each party from all of the defendants. This statute was upheld as constitutional in *Samsel v. Wheeler Transport Services, Inc.*, 246 Kan. 336 (1990).

Kentucky – Constitution prohibits caps on damages

Maryland – The judge may award up to 150% of the limit.

Massachusetts – The cap does not apply if there is proof of substantial disfigurement, permanent loss or impairment, or other special circumstances that warrant a finding that imposition of such limitation would deprive the plaintiff of just compensation for the injuries sustained.

Michigan – The cap is adjusted annually for inflation. The cap was also upheld in *Zdrojewski v. Murphy*, 202 Mich. App. Lexis 1565 (2002).

Missouri - In *Scott v. SSM Healthcare*, the court held Missouri's cap can be applied separately for each act of malpractice. Therefore, if there are two separate and distinct "occurrences" of malpractice that contribute to a single injury the court can apply a separate cap for each occurrence even if they are applied to a single defendant. *Scott v. SSM Healthcare*, 70 SW 3d 530 (Ct. App. 2002).

Nebraska - In 2003, the Nebraska legislature increased the total cap to $1.75 million. The cap applies to health care providers who qualify under the Hospital-Medical Liability Act (i.e. carry minimum levels of liability

insurance and pay surcharge into excess coverage fund). Qualified providers shall not be liable for more than $200,000 in total damages with any excess damages paid from the excess coverage fund.

Nevada - the $350,000 cap applies to each defendant.

New Jersey – Since this chart focuses on state laws on non-economic damages, we suggest deleting the reference to these bills from the chart because they have not yet been enacted.

New Mexico – For consistency should specify that qualified health care providers are not liable for more than $200,000 with any award in excess paid for through the patient compensation fund.

Ohio – The explanation of Ohio's law should be clarified. The cap on non-economic damages is limited to the greater of $250,000 or an amount equal to three times the plaintiff's economic loss up to a maximum of $350,000 for each plaintiff or $500,000 if there are multiple plaintiffs. Non-economic losses for permanent and substantial physical deformity or a permanent physical functional injury is limited to $500,000 per plaintiff or $1 million for multiple plaintiffs.

Pennsylvania – The limits described in the chart are not a cap on non-economic damages. Rather this is the maximum amount Pennsylvania's MCARE fund, a patient compensation fund, will be liable for in damages. Therefore, this should be deleted from the chart.

Texas – Legislature enacted a new cap in 2003. Under the new cap, judgments against physicians and health care providers are limited to $250,000 in noneconomic damages; a separate cap of $250,000 in noneconomic damages applies to a judgment against a single health care institution; a judgment made on any subsequent health care institution is also limited to $250,000 in noneconomic damages with not more than a total $500,000 judgment against all health care institutions.

Utah – This cap provision is misstated in the chart. For causes of action arising on or after July 1, 2001 but before July 1, 2002, non-economic damages are limited to $250,000. For causes of action arising on or after July 1, 2002, the cap increases to $400,000. Thereafter, the cap will be adjusted annually for inflation.

West Virginia – Legislature enacted new cap in 2003. The new law provides a $250,000 cap on noneconomic damages per occurrence. The cap increases to $500,000 for cases involving (1) wrongful death, (2) permanent and substantial physical deformity, loss of use of limb or loss of a bodily organ system, or (3) permanent physical or mental functional injury that permanently prevents the injured person from being able to independently care for himself or herself and perform life sustaining activities. Cap is adjusted annually for inflation, but the $250,000 cap shall not exceed $375,000 and the $500,000 cap shall not exceed $750,000.

Wyoming – Constitution prohibits caps on damages.

(pg. 65) In the second paragraph, the NAIC report describes the differences in application among states with a total cap on damages. The AMA working group should include a similar sentence describing the differences among states with a cap on non-economic damages because these variations can have a dramatic impact on the cap's effectiveness. For example, California has a hard cap with no exceptions and no adjustments for inflation or other factors. By contrast, some states have exceptions for certain injuries, apply the cap to each defendant, or increase the cap annually based on inflation or another factor, all of which weaken the cap's effectiveness.

(pg. 68) While the GAO report states that due to data limitations it is not possible to quantify the impact of a cap on non-economic damages on insurers' losses, the report goes on to state that "[m]ultiple factors have combined to increase medical malpractice premium rates over the past several years, but losses on medical malpractice claims appear to be the primary driver of increased premium rates in the long term. Such losses are by far the largest component of insurer costs, and in the long run, premium rates are set at a level designed to cover anticipated costs." The AMA believes this information should be included in the report.

(pg 68) The AMA believes the reference to Ross (30 Ind. L. Rev. 594) should be deleted. While everyone is entitled to their opinion, Ross' opinion as cited in the report has been invalidated by several state supreme courts which have upheld state laws that place limits on damages, finding that these laws did not violate the equal protection clause of the state or federal constitution. Courts have also upheld state laws placing caps on damages based on the due process clause, right to a trial by jury, open court doctrine, and intrusion on the rulemaking power of the legislative branch. In addition, Ross' statement that caps on damages are "unlikely to effectuate their intended purpose of lowering malpractice insurance premiums and health care costs" is based purely on opinion without any supporting data. Including this reference among references to peer reviewed economic literature is highly misleading.

***Collateral Source Rules***

(pg. 69-70) The AMA believes collateral source reform is an integral part of a medical liability reform package because it eliminates double recoveries. However, the description of the collateral source rule in the report is a bit confusing because the term "collateral source rule" is also used to describe collateral source reform. The collateral source rule is a common law evidentiary rule which prohibits information concerning payments made to the plaintiff from collateral sources, such as health insurance or disability insurance, from being submitted as evidence. Over thirty states have enacted collateral source reform laws to eviscerate this rule, allowing such information to be submitted to the judge or jury for consideration in awarding damages. In many states the law simply allows the information on payments made by collateral sources to be admitted as evidence. Other states also allow the plaintiff to submit evidence of payments made on his or her behalf to secure such benefits, such as health insurance deductibles or co-payments. Finally, some states require the judge or jury to decrease the award based on payments received from collateral sources. California's MICRA law simply allows information on payments made by collateral sources to be admitted as evidence for consideration by the jury.

In addition, the discussion of subrogation is confusing. Most insurers, including health insurers, include a subrogation clause in their contract which allows the insurer to place a lien on any judgment or damage award received by the plaintiff where a third party caused harm. A well crafted collateral source reform law would prohibit a health or disability insurer from invoking this subrogation clause to take money from the plaintiff's award, thereby eliminating the possible "double reduction" of a plaintiff's award that would occur if the judge or jury reduced a

plaintiff's judgment based on payments made from collateral sources and did not limit subrogation. In this scenario, the collateral benefit provider could place a lien on the already reduced award to recover their payments from the plaintiff, resulting in a double reduction. Not limiting subrogation primarily benefits health plans and other health care insurers at the expense of injured patients, physicians, hospitals, other health care professionals, and medical liability insurers.

The AMA would encourage the working group to incorporate this distinction into the report to facilitate understanding of a complicated issue and to take this into consideration when drafting the group's recommendations. In addition, the AMA encourages the working group to include a recommendation in the final report supporting collateral source reform

*Periodic Payment of Future Damages*
The AMA believes that periodic payment of future damages is a key element of any medical liability reform package because it ensures the plaintiff has money available when he or she needs it and allows an insurer to more accurately estimate future losses. The AMA encourages the working group to include a recommendation in the final report supporting periodic payment of future damages.

*Contingency Fee Limitation*
Many people realize that in addition to paying up to 50% of his/her award in contingency fees, all court costs, expert witness fees, deposition costs, and other expenses must also be paid out of the plaintiff's judgment. Thus, a large percentage of any award is never actually received by the plaintiff. The AMA believes that placing limits on contingency fees is crucial to any liability reform package, because it allows patients to receive a greater portion of any recovery. The AMA encourages the working group to include a recommendation in the final report supporting limits on attorney contingency fees.

To strengthen this section of the report, the AMA makes the following recommendations:

(pg. 77) The AMA encourages the NAIC to make the distinction between attorney contingency fees and other costs associated with a trial. A successful plaintiff is typically financially responsible for court costs, expert witness fees, deposition costs, etc. in addition to attorney fees. These costs can eat up a substantial part of a plaintiff's recovery.

(pg. 79) The AMA believes the references to Public Citizen's paper *Medical Misdiagnosis* in the NAIC report is misleading because many claims asserted in *Medical Misdiagnosis* have no supporting data and in fact are contrary to findings based on independent peer reviewed data. The AMA, therefore, respectfully requests references to Public Citizen's *Medical Misdiagnosis* be deleted from the report.

(pg. 79) The reference to McMullen's quote on mediation would be more useful for the reader if it were placed in the section on Alternative Dispute Resolution mechanisms.

(pg. 79-80) The AMA believes the reference to Reames (62 Chi. Kent L. Rev. 271) should be deleted because it is based purely on the author's opinion and misrepresents California law. California's Supreme Court repudiated this type of argument made by Reames in *Roa v. Lodi Medical Group, Inc.*, 37 Cal. 3d 920 (1985). In *Roa* the court upheld the statute placing a limit on attorney contingency fees as constitutional because it is rationally related to the legitimate state purpose of reducing medical malpractice premiums. Furthermore, Reames statement that "[w]ithout a qualified attorney, a malpractice victim's right to petition for redress is a nullity" is

inaccurate. Limiting attorney contingency fees does not prohibit an individual from his/her day in court. Since fee limitations are structured progressively, typical contingent fee amounts do not begin to see limitations until the plaintiff's award reaches a significant threshold. Based on the foregoing, the AMA respectfully requests that the reference to Reames article be deleted from the report.

*Legislative Strategy Regarding Bad Faith*
The report fails to provide any details on how the NAIC is considering changes to laws regarding bad faith. It is difficult, therefore, to comment on this section. Yet, the AMA cautions that changes to bad faith laws may fail to address the systemic problem identified by the GAO as causing the medical liability crisis – an increase in jury awards driven by our out-of-control litigation system.

*Alternative Dispute Resolution and Mediation*
While ADR mechanisms may streamline the litigation process, if not structured properly they could also prolong the process by creating one more hurdle for the parties involved. This could in turn increase everyone's expenses and waste valuable time. The effectiveness of ADR is also dependent on the existence of other tort reform measures that address the root of the problem – high jury awards. Prior to making any recommendations on ADR, the AMA encourages the working group to review state efforts to use ADR mechanisms to resolve medical liability cases.

*Special Courts*
The use of special courts has proven effective in other areas of the law, such as workers compensation. The AMA has developed suggestions for a fault-based administrative system for resolving medical liability disputes and encourages the development of a state based demonstration project to implement this system. (see AMA report attached) Readers may find reference to the AMA's suggestions helpful.

*Patient Compensation Fund*
Patient compensation funds for all types of injuries have been enacted in nine states, including Indiana, Kansas, Louisiana, Nebraska, New Mexico, New York, Pennsylvania, South Carolina, and Wisconsin. Most of these funds were implemented during the medical liability crises in the 1970s or early 1980s and have experienced varying degrees of success in stabilizing the medical liability insurance markets in their states. In all states with a patient compensation fund, except New York, the fund is financed exclusively by surcharges on health care providers. Therefore, without a meaningful cap in place, the fund may not reduce the overall cost of medical liability insurance. Rather it will simply shift costs from the traditional insurer to the patient compensation fund. The AMA believes that evidence demonstrates that a patient compensation fund will be successful in stabilizing a medical liability market only if it is coupled with an effective damage cap. The AMA encourages the working group to compare funds in various states, including Indiana, Louisiana, and Pennsylvania before deciding whether patient compensation funds should be recommended as a viable tort reform measure.

*Alternative Treatment of Trauma Centers and High Risk Specialties*
Since the late 80s, Florida and Virginia have had an alternative mechanism to compensate patients who have suffered a serious birth related neurological injury in place, however, neither of these mechanisms have been effective in stabilizing the medical liability market. More recently Nevada and Oklahoma enacted reforms aimed at specialties. In 2002, Nevada's legislature enacted a separate $50,000 cap on civil damages for care related to a trauma injury. In 2003 Oklahoma's legislature enacted a $300,000 cap on non-economic damages in cases involving pregnancy, labor and delivery, or care provided immediately post-partum. Despite passage of

these reforms, medical liability carriers are continuing to flee both of these states. Furthermore, one must question whether addressing the symptom in some specialties will only exacerbate the problem in other specialties. The AMA encourages the NAIC to carefully review these state experiences before making any recommendation as to the effectiveness of this approach.

*Patient Safety Measures and Data Reporting Issues*
The AMA applauds the NAIC for including a section on patient safety measures. As discussed in the report, the AMA is committed to promoting a meaningful long-term approach to ensuring greater patient safety in the delivery of health care in our nation. (H-335.965). The AMA encourages the NAIC to include a recommendation supporting a confidential non-punitive error reporting mechanism using the federal Aviation Safety Risk Analysis Program as a guide.

Finally while it is not specifically addressed in the report, the AMA would again like to encourage the NAIC to support a recommendation that reforms should be aimed at the state and federal level. While the AMA has always been and will continue to be a strong supporter of states' rights, the current crisis is a national problem in at least 45 states, including 19 states identified by the AMA as in crisis and an additional 26 states showing clear danger signs of joining them. It is clear this is a national problem that requires a national solution. That said, the AMA will not support any federal effort that would undermine effective tort reform enacted in the states.

On behalf of the AMA, thank you for your consideration of our comments on the latest draft of the report. We look forward to discussing them with you at the next working group meeting. In the meantime, please do not hesitate to contact me directly at (312) 464-5033 if you have any questions or would like additional information on any concerns raised in the letter.

Sincerely,

Kimberly Horvath, JD

cc: Eric Nordman, CPCU, CIE
David Cermak

Enclosure