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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

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[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

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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

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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

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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

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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.

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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.

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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

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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,[illegible],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,[illegible]77
MS	58	63,6[illegible]2,554	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

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State	Number of Insurers	Total	Mean	Standard Deviation	Median	Maximum
NC	74	220,335,540	2,977,507	8,504,447	5[illegible]7,659	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	382,697	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.

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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	2,152,016	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.

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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	3,163,314	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

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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.

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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	38,757,799	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.

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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,[illegible]43	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	[illegible],269,553	0	[illegible],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

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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	31,113,457
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.

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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,[illegible]24,576

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	5,406,134	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

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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.

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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*	Underwriting 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	161,227,495	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	8,333,024,031	2,449,911,505	9,557,804,173	112.82%	87.19%	25.63%

Source: National Association of Insurance Commissioners.

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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%	(5.80%)
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	88.70%	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.

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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	61,286,757	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.

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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.

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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.

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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.

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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	1,585,505,063
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.

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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 Association 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.

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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.

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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	596,081	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.

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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.

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Table 29 - Capital and Surplus Requirements, By State

[TO BE ADDED]

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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 Mkt. 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	319,435,442	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.

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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	153,648,074	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	322,113,305	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	52,336,057	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%	0.88%	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%	0.57%	28.54%	0.21%	1.28%	.	1.65%
NM	53,023,274	54.84%	7.34%	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.

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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.	

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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 Oct.ber 1 thereafter, the limit on non-economic damages is increased by $15,000.	
MA	§ 231: 60H	In any action for malpractice, the court may not award the plaintiff more than $500,000 for pain and suffering, loss of companionship, embarrassment and other items of general damages.	
MI	§§ 600.1483, 600.6304	The total amount of damages for non-economic loss recoverable by all plaintiffs cannot exceed $280,000. Exceptions allow the court, in some circumstances, to maximize damages to no more than $500,000. The court will reduce a jury award in excess of this amount.	
MN	None	No medical malpractice caps.	
MS	§ 85-5-7	The limit for non-economic damages cannot exceed $500,000 if the claim was filed after passage of House Bill No. 2, but before 07/01/2011. Any claim filed on or after 07/01/2011, but before 07/01/2017, the amount of non-economic damages cannot exceed $750,000. For claims on or after 07/01/2017, the amount of non-economic damages cannot exceed $1,000,000.	
MO	§ 538.210 See also Missouri HB 273	In 1986, the Missouri General Assembly enacted a $350,000 per occurrence limit for non-economic damages. This limit is subject to annual adjustments by the Director of the Division of Insurance to reflect increases in the consumer price index. In 2003, the Director of Insurance set the limit for non-economic damages at $557,000.	The medical malpractice cap was declared constitutional in Adams v. Children's Mercy Hospital, 832 S.W.2d 898 (Mo.), cert. denied, 506 U.S. 991 (1992).
MT	§ 25-9-411	In a malpractice claim or claim against one or more health care providers based on a single incident of malpractice, an award for past and future damages for non-economic loss cannot exceed $250,000.	

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

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

Source: National Association of Insurance Commissioners.

Table 36 - States That Have Enacted Patient Compensation Funds

Medical Liability Insurance

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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): 663-669.* 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 1566 (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 wo[illegible] 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

SB

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(FILE 4 OF 5)

Governor's Select Task Force on Healthcare Professional Liability Insurance

University of Central Florida

Office of the President

January 29, 2003

The Honorable Jeb Bush
Office of the Governor
State of Florida
PL-05 The Capitol
4000 South Monroe Street
Tallahassee, Florida 32399-0001

Dear Governor Bush:

I am pleased to transmit with this letter a copy of the report and recommendations of the Governor's Select Task Force on Health Care Professional Liability Insurance. In addition, we are submitting 13 volumes of reports, presentations, letters, and testimony.

During the past five months, the task force studied the history of medical malpractice and the current medical malpractice crisis in Florida, heard extensive testimony from healthcare providers and malpractice victims at hearings throughout the state, read hundreds of letters from concerned citizens, and conducted our own independent research of published studies and relevant literature.

The task force has taken great care to conform its recommendations to the requirements of the Florida Constitution and case law and to incorporate the thoughts and comments of the various stakeholders who addressed our group on this complex issue.

My fellow task force members and I are hopeful that this report will make a significant contribution to solving this crisis. We are grateful for the opportunity to serve, and we offer our continued assistance in the upcoming legislative session.

Cordially yours,

John C. Hitt
President

JCH/sc
enclosures

c: The Honorable Johnnie Byrd, Speaker of the House
The Honorable Jim King, President of the Senate

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Executive Summary

"Is there a doctor in the house? Increasingly, in Florida and around the country, the answer is no—not in the house, not in the doctor's office, and not in the hospital. Many physicians are choosing to retire early or to practice in other states because medical malpractice insurance in Florida has become unaffordable and, in some cases, unavailable."

James C. McDowell, Is There a Doctor in the House?, 23 The Journal of the James Madison Institute 10 (Winter 2003)

Florida is among the states with the highest medical malpractice insurance premiums in the nation. This increase in healthcare liability insurance rates is forcing physicians to practice medicine without professional liability insurance, to leave Florida, to not perform high-risk procedures, or to retire early from the practice of medicine.

In April 2002, the American Medical Association issued a report declaring Florida one of the twelve states in the midst of a medical liability insurance crisis. This crisis in the availability and affordability of medical malpractice insurance is causing a critical reduction in the quality of healthcare available in Florida. If no corrective action is taken, this crisis will lead to the continued deterioration of patient access to medical care.

During the past three years, numerous healthcare liability insurance carriers in Florida have been liquidated, forced into rehabilitation, or have decided to stop selling medical malpractice insurance in Florida. In the late 1990s, there was an industry high of sixty-six insurance companies active in Florida. Since that time, the number of companies has decreased to only twelve. Those remaining companies are quickly reaching capacity and are unable to expand their risk base to cover the physicians whose policies are being terminated by other companies.

The Governor's Select Task Force on Healthcare Professional Liability Insurance was created on August 28, 2002 by Executive Order No. 02-041, to examine Florida's current crisis in the availability and affordability of medical malpractice insurance. The Executive Order also directed the Task Force to make

recommendations for "protecting Floridians' access to high-quality and affordable healthcare."

The Task Force had ten meetings. During these meetings, the Task Force received testimony and information in five major areas which impact Floridians' access to high-quality and affordable healthcare. The Task Force examined healthcare quality issues and how those issues are impacted by medical malpractice insurance rates. The Task Force further reviewed state procedures for healthcare professional discipline. Likewise, the tort system's impact on the frequency and severity of claims was examined extensively. Moreover, the Task Force examined alternative dispute resolution processes in order to ensure victims of medical malpractice are fairly compensated for injuries in a timely manner. Finally, the Task Force examined factors influencing medical malpractice insurance rates and the regulation of rate setting by the state along with suggestions for improving the rate setting process to reduce the impact of the insurance business cycle. In sum, these areas can be divided into the following five categories: (1) healthcare quality; (2) physician discipline; (3) the need for tort reform; (4) alternative dispute resolution; and (5) insurance premiums and markets.

In addition to receiving information on the medical malpractice crisis the Task Force requested interested persons and entities to provide proposed solutions to the problem. The Task Force, as a result of this request, received over 100 proposals for change. In reviewing the proposals the Task Force used the following four criteria:

- Would the proposed change improve access to specialists, critical care providers, medical facilities for emergency care, obstetrical services, neurological services, or surgery?

- Would the proposed change facilitate the availability of malpractice insurance or other means for injured parties to recover reasonable compensation for injuries caused by the negligent acts of healthcare providers?

- Would the proposed change facilitate identifying and addressing healthcare provider problems as soon as possible to reduce or eliminate the risk to patients?

- Would the proposed change assist in reducing or holding down the cost of medical care to citizens and their health insurance providers to facilitate access to healthcare?

The reports and information received by the Task Force as well as transcripts of the meetings are compiled in the thirteen volumes that accompany the main report. The Governor, the President of the Senate, the Speaker of the House of Representatives, and the Legislative Library will be presented with the main report and the thirteen volumes. Thus, it must be emphasized that in order to properly understand the context of these findings and recommendations, we encourage the reader to read the entire text of the main report. The contents of this report were approved by the Task Force in a 4-0 vote on January 30, 2003.

The Task Force proposes a comprehensive solution, in the following five areas of reforms: (1) healthcare quality (2) physician discipline; (3) tort compensation; (4) alternative dispute resolution; and (5) insurance code reform.

Based on the testimony and information received and legal research of the Task Force's staff, the Task Force makes the following findings and recommendations to address the medical malpractice crisis in Florida.

Findings

Affordability: The cost of medical malpractice insurance has increased dramatically during the last few years. In 2002 the average medical malpractice premium per doctor in Florida was 55 percent higher than the national average. Florida's average insurance premiums have increased 64 percent since 1996 while nationally the average insurance premiums have increased 26 percent.

Availability: The number of insurance companies writing medical malpractice policies in Florida went from a high of sixty-six companies in 1999 to twelve currently, and of the twelve currently writing premiums only four are generally writing medical malpractice insurance. The remaining eight are writing only selected policies.

Impact of the Underwriting Cycle: The business cycle for medical malpractice insurance companies has had a significant impact on the increases in medical malpractice insurance levels in Florida but

claims paid has been the main cause of such increases. The late-1990s produced some of the largest investment gains for the market since the mid-1980s, but this increased income was not sufficient to offset the large increases in claims paid for the industry. As a result, insurance companies writing medical malpractice insurance suffered a loss ratio of 184 percent.

Frequency of Claims Payments: Florida's claims frequency which was an average of 4.82 claims per 100,000 population in 1991 has increased to an average of 7.56 claims per 100,000 in 2000. The national average has been between 5.11 and 5.77 claims from 1991 to 2000 with an average of 5.54 claims per 100,000 population in 2000. Thus, in 2000, Florida's frequency of claims was 36 percent higher than the national average.

Severity of Claims Payments: The severity of claims in Florida and nationally showed a significant increase between 1998 and 2000. Further, the average "per premium" loss per Florida doctor has grown from 15 percent above the national average in 1991 to 50 percent above that average in 2000.

Variations Among Medical Specialties: Specialists and other physicians performing high-risk procedures are much more likely to be sued. These specialists, particularly obstetricians and neurosurgeons, also pay much higher medical malpractice insurance rates, regardless of their litigation history.

Changes in the Law: The very existence of the continuing medical malpractice crisis is proof that the previous reforms have failed to provide a solution to the problem. Florida's use of many of the reforms considered or adopted by other states further demonstrates that the provisions related to medical malpractice adopted in Florida have not been sufficient in addressing the problem. The limitation on damages, the only provision proven to be effective in reducing the severity of judgments, was stricken by the Florida Supreme Court.

Access to Healthcare Services: The concern over litigation and the cost and lack of medical malpractice insurance have caused doctors to discontinue high-risk procedures, turn away high-risk patients, close practices, and move out of the state. In some communities, doctors have ceased or discontinued delivering babies and discontinued hospital care.

Compensation of Victims: As the cost of medical malpractice insurance has increased some healthcare providers carry only

minimum insurance of $250,000 or are "going bare." This leaves victims with minimal or no compensation should they be injured.

Professional Regulation of Medical Care: The current disciplinary process requires the Division of Administrative Hearings judges to make the determination when conduct fails to meet minimum standards of care and is formally charged against a healthcare provider or facility. Frequently those rulings frustrate and thwart the ability of the healthcare provider regulatory boards to appropriately discipline healthcare providers. Issues such as defining the standard of care in a given set of facts and whether the practitioner breached that standard are responsibilities best left to the professional boards. Additionally, hospitals find it very difficult to discipline or remove healthcare professionals for actions below the accepted standard of care.

Recommendations

Healthcare Quality

Recommendation 1. The Legislature should establish a Patient Safety Authority, or an entity similar in concept, as both a short-term and long-term strategy to improve patient safety. There are two options that should be considered. The first option, which is recommended by the Institute of Medicine (IOM), is to have two systems, one for the mandatory reporting of adverse events and another system for the voluntary reporting of near misses. The second option is similar to the Patient Safety Authority established and existing in Pennsylvania, which analyzes all adverse events and near misses in that state. Experts employed by both systems would analyze data received and make recommendations about how to reduce these adverse events and near misses. Information would not be subject to discovery in lawsuits.

Recommendation 2. The Legislature should timely develop or adopt statewide electronic medical records and protocols for a physician medication ordering system. The system should be developed collaboratively with hospitals, physicians, and other healthcare providers. The physician medication ordering system should be implemented first. The system could be implemented initially with a web-based data exchange platform which establishes interconnectivity among providers. Another possibility is to begin with business functions, which provide an early return on investment, and then include clinical functions.

Recommendation 3. The Legislature should consider creating a statutory public-private non-profit entity that would administer the Patient Safety Authority, statewide electronic medical records, and build an information technology infrastructure to support the delivery of healthcare that would include a statewide physician medication ordering system. Funding could possibly come from a $1 per year surcharge on all health professional licenses; all hospital, ambulatory care surgery center, nursing home, home health agency, and birth center discharges; and all individuals in managed care plans and insurance plans licensed under chapters 627 and 640, Florida Statutes. Healthcare providers, insurers, businesses, and government would be represented on the governing board of directors. Options for implementation include:

- Affiliating with a university for the analysis of voluntarily reported adverse events and "near misses."
- Contracting with an Information Technology firm(s) for a statewide physician medication ordering system, web-based platform for health provider interconnectivity, and electronic patient record.
- Developing a business plan and future financing strategy to supplement the $1 annual surcharge, which will likely be necessary to achieve full implementation.
- Including in the business plan a strategy to begin with computerizing business functions, for providers to quickly achieve cost-savings due to automation efficiencies, and then include clinical functions.

Recommendation 4. The Legislature should be encouraged to authorize the two "no fault" medical malpractice demonstration projects recommended in the November 2002 report, Fostering Rapid Advances in Healthcare, by the IOM at a university healthcare system or statutory teaching hospital. This project would be governed by criteria compatible with that proposed by the IOM.

Recommendation 5. If Recommendation 4 is implemented, contingency fees for attorneys should be eliminated from the claims bill process in the no-fault demonstration project.

Recommendation 6. The Legislature should require each hospital and ambulatory surgery center to have a patient safety plan, a patient safety committee, and a patient safety officer. Members of the public should have representation on patient safety committees.

Recommendation 7. The Legislature should require healthcare providers to notify patients who experience serious medical injuries to be notified of the injury in person.

Recommendation 8. The Legislature should examine the feasibility of using Medicaid funding to create a pilot project for an electronic medical record and a physician medication ordering system for Medicaid patients.

Recommendation 9. The Legislature should examine the feasibility of developing a process in the Insurance Code for hospitals and other healthcare facilities to receive malpractice insurance discounts if they implement certified patient safety programs.

Recommendation 10. The Legislature should establish a high-technology simulation center for use by all health providers. Florida should encourage use of this center by practitioners in other states to help offset the costs for the center.

Recommendation 11. The Legislature should require all medical schools, nursing schools, and allied health schools to include in their curricula courses on patient safety and patient safety improvement.

Recommendation 12. The Legislature should require the Agency for Health Care Administration (AHCA) to conduct a study to determine if it is feasible to provide information to the public to help them make better healthcare decisions regarding the choice of a hospital. The information would not be presented in a "report card" format. AHCA should be provided with sufficient resources to conduct the study in cooperation with hospitals, physicians, and other healthcare providers and provide the Governor and Legislature with a report.

Physician Discipline

Recommendation 13. The Legislature should allow the healthcare provider regulatory boards to appoint administrative law judges with expertise in the profession to hear standard of care cases.

Recommendation 14. The Legislature should statutorily provide that standard of care decisions are, as a matter of law, infused with

overriding policy considerations best left to the healthcare provider regulatory boards.

Recommendation 15. The Legislature should authorize the healthcare provider regulatory boards to reassess and resolve conflicting evidence in standard of care cases based on the record in the case.

Recommendation 16. The Legislature should require physician profiles to provide professional qualifications information regarding physicians to consumers.

Recommendation 17. The Legislature should provide for an audit of the Department of Health's (DOH) disciplinary process and closed claims files.

Recommendation 18. The Florida Legislature should strengthen Florida's peer review requirements so they can lead to earlier dismissal of meritless claims brought against hospitals by aggrieved physicians and protect physicians and hospitals from costly lawsuits and liability.

Recommendation 19. The Legislature should expand the DOH's subpoena authority to include the retrieval of patient records when the patient refuses to cooperate, is unavailable, or fails to execute a patient release. Records obtained under these circumstances would be confidential.

Recommendation 20. The Legislature should require that all first offense citations be non-disciplinary and non-reportable to the national data banks.

Recommendation 21. The Legislature should expand the timeframe for forwarding cases to the Division of Administrative Hearings from fifteen days to forty-five days when a demand for a formal hearing, pursuant to section 120.57(1), Florida Statutes, is received.

Recommendation 22. The Legislature should require all healthcare provider regulatory boards to designate those violations that may be handled in a one-time, non-reportable, and confidential mediation proceeding. Appropriate standard of care cases should be included.

Recommendation 23. The Legislature should modify upward the dollar amount threshold for closed claims cases to be reported and investigated by the Department.

Recommendation 24. The Legislature should grant exclusive authority to the healthcare provider regulatory boards to determine the amount of administrative costs to be recovered when final action occurs and a respondent is disciplined.

Recommendation 25. The Legislature should change the burden of proof in disciplinary actions from the "clear and convincing evidence" standard, to the "greater weight of the evidence" standard, which is the same burden of proof for a medical malpractice case.

Recommendation 26. The Legislature should expand the healthcare provider regulatory board's rulemaking authority in the areas of Internet prescribing and sexual misconduct cases so as to better address critical areas of discipline.

Tort Reform

Cap on Non-Economic Damages

Recommendation 27. The Legislature should, in medical malpractice cases, cap non-economic damages at $250,000 per incident. The Task Force believes that a cap on non-economic damages will bring relief to this current crisis. Without the inclusion of a cap on potential awards of non-economic damages in a legislative package, no legislative reform plan can be successful in achieving the goal of controlling increases in healthcare costs, and thereby promoting improved access to healthcare. Although the Task Force was offered other solutions, there is no other alternative remedy that will immediately alleviate Florida's crisis of availability and affordability of healthcare. The evidence before the Task Force indicates that a cap of $250,000 per incident will lead to significantly lower malpractice premiums.

The Legislature should commission and fund a study of the impact of the $250,000 cap on non-economic damages. An interim report should be submitted to the legislature five years after date of enactment.

Communications with Subsequent Treating Physicians

Recommendation 28. The Legislature should amend the statutes to allow *ex parte* communication between defense counsel for a defendant in a medical malpractice lawsuit and the plaintiff's treating physicians.

Recommendation 29. As an alternative, the Legislature may consider requiring the plaintiff to execute a medical information release when filing a lawsuit that would allow for the defendant to conduct *ex parte* interviews with the plaintiff's treating physicians only in areas potentially relevant to the plaintiff's alleged injury or illness.

Expert Witness Qualifications

Recommendation 30. The Legislature should examine ways to improve the use of in-kind experts at trial.

Limitation on Liability Related to Emergency Services

Recommendation 31. The Legislature should retain the definition of "reckless disregard," as that term is currently defined by statute, as it is sufficient.

Recommendation 32. The Legislature should repeal references to patient stabilization in section 768.13(2)(b)2a, Florida Statutes.

Sovereign Immunity

Recommendation 33. The Legislature should amend section 768.28, Florida Statutes, to define healthcare professionals providing services in emergency rooms or trauma centers as agents of the state for purposes of sovereign immunity.

Periodic Payment of Damages

Recommendation 34. The Legislature should amend the statutes to allow the periodic payment of future non-economic damages.

Recommendation 35. The Legislature should amend the statutes to terminate the payment of future economic and non-economic damages upon the death of the plaintiff.

Pre-Suit Reform

Recommendation 36. The Legislature should require experts reviewing pre-suit claims and defenses and rendering opinions be qualified, in that they possess similar if not identical credentials and expertise in the field of healthcare services of the defendant's particular specialty.

Recommendation 37. The Legislature should require the expert who reviews pre-suit claims and defenses and renders opinions be subject to discovery and his or her testimony be admissible in any future proceeding.

Joint and Several Liability

Recommendation 38. Joint liability has a negative impact on a medical malpractice insurer's ability to forecast future losses and contributes to the insurer's paid losses. Accordingly, the Legislature should amend section 768.81, Florida Statutes, to provide that a defendant's liability for both economic and non-economic damages be several only.

Set Off of Settlement Proceeds

Recommendation 39. The Legislature should amend the set off statutes, sections 46.015 and 768.041, Florida Statutes, to clarify that set off amounts should be applied to jury damage awards, including both economic and non-economic damages, even when fault is several only.

Alternative Dispute Resolution

Mandatory Mediation

Recommendation 40. The Legislature should encourage pre-suit mediation by providing for confidentiality of any pre-suit

mediation in a medical malpractice case in the same manner as is provided for mediation occurring after suit is filed.

Recommendation 41. The Legislature should amend the mandatory mediation provisions of section 766.108, Florida Statutes, to require mediation within 120 days of filing suit and to provide sanctions if a good faith offer of settlement is refused.

Recommendation 42. The Legislature should not make admissible at trial the fact that mandatory mediation occurred or that offers of settlement were made, but should make this fact admissible for purposes of enforcing the attorney fees and costs. The mediator should maintain a report of the issues and facts presented at the mediation and the final settlement offers of each party at the mandatory mediation.

Recommendation 43. The Legislature should enact specific criteria similar to those in the offer of judgment statute to be considered by the court in making the determination as to how close in amount the judgment must be to the offer and the criteria to be used in evaluating the amount of the attorney fees and costs to be awarded in addition to the standards generally considered in awarding fees and costs.

Recommendation 44. The Legislature should require the court to consider, in addition to all other criteria, whether the issues and facts presented at mediation were significantly the same issues presented at trial.

Voluntary Binding Arbitration

Recommendation 45. The Legislature should amend the definitions of "economic damages" and "non-economic damages" as provided in sections 766.202 and 766.207, Florida Statutes, to provide that such damages are recoverable in voluntary binding arbitration only if the claimant has the right to recover such damages under general law, including the Wrongful Death Act.

Recommendation 46. The Legislature should provide for an aggregate cap on non-economic damages in arbitrated cases of multiple defendants.

Insurance Reform

NICA

Recommendation 47. The Legislature should maintain the NICA program because of its success and should further consider and study the issues for broadening the NICA program, as discussed in this report.

Bad Faith

Recommendation 48. The Legislature should restore the insured as the owner of the bad faith cause of action. The common law cause of action, as outlined by the Supreme Court in 1980 should be legislatively cured so that the Florida Legislature preempts that rule and only insureds, not third party plaintiffs, can bring a bad faith cause of action against its insurer. In addition, section 624.155, Florida Statutes, should be amended to also limit the proper party in a bad faith cause of action to the insured only.

Recommendation 49. The Legislature should articulate standards of what constitutes bad faith on the part of an insurer.

Recommendation 50. The Legislature should require that the maximum liability for bad faith be calculated as the amount of damages that were actually caused by the acts of bad faith, limited by the amount of the reachable assets of the insured.

Recommendation 51. The Legislature should require that, if an insurer is found to be in bad faith or settles a case for bad faith, the Department of Insurance be notified of such finding.

Recommendation 52. The Department of Insurance should conduct an investigation into the specific allegations of the insurer and into the insurer's general practices and should take necessary action against the insurer to punish and prevent future bad faith practices.

Alternative Insurance Products

Recommendation 53. The Legislature should repeal the prohibition against creating Medical Malpractice Risk Management Trust Funds in section 627.357, Florida Statutes.

Recommendation 54. The Legislature should encourage the creation of self-insured options for healthcare providers.

Recommendation 55. The Legislature should expand the rulemaking authority of the Department of Insurance for self-insurance programs to ensure they remain solvent and provide the insurance coverage purchased by participants.

Insurance Company Regulation

Recommendation 56. The Legislature should authorize the Department of Insurance to require insurers to provide additional information on closed claims and to penalize the insurers for failure to provide the required data.

Recommendation 57. The Department of Health should forward the information collected pursuant to section 456.049, Florida Statutes, to the Department of Insurance.

Recommendation 58. The Legislature should require every entity reporting to the National Practitioner Data Bank to report the same information to the Department of Insurance for inclusion in the closed claim data files.

Recommendation 59. The Legislature should require the Department of Insurance to compile and review the collected data and fine those entities failing to fully comply with the requirements of law.

Recommendation 60. The Legislature should include in section 627.062, Florida Statutes, related to the setting of rates for most insurers, the provisions of section 627.0651(12), Florida Statutes, prohibiting the inclusion of payments made by insurers for bad faith or punitive damages claims.

Conclusion

Although all of the above recommendations are important, the most important one is a cap on non-economic damages in the amount of $250,000. In an Issue Brief on federal medical malpractice tort reform, the American Academy of Actuaries recommend that Congress look to California's successful experience with a cap on non-economic damages. The Academy concluded:

> For reform to be effective in reducing costs, the cap on non-economic awards should be established on a per-medical-injury basis at a level low enough to have an impact (e.g., $250,000).

In light of this recommendation of the Academy of Actuaries and California's successful experience at the $250,000 level, the Task Force finds that a cap at the level of $250,000 on a per incident basis will be effective.

The Task Force finds that actual and potential jury awards of non-economic damages (such as pain and suffering) are a key factor (perhaps the most important factor) behind the unavailability and un-affordability of medical malpractice insurance in Florida. The Task Force further finds that malpractice insurance premiums are a large component of the cost and availability of healthcare in Florida.

Based upon the evidence before it, including evidence of Florida's unsuccessful previous efforts to eliminate the ongoing medical malpractice crises, and the successful experiences of other states that have imposed caps on potential jury awards of non-economic damages, the Task Force finds that imposing caps on non-economic damages in medical malpractice cases will significantly reduce the exposure of Florida healthcare providers to risk of loss from jury awards of inherently subjective damages. Such a reduction of risk will make malpractice losses much more predictable, and thereby lead to stability in malpractice insurance premium rates.

A reduction in potential liability and resulting stability will encourage more malpractice insurers to participate in the Florida market. This, along with the reduced exposure to risk, will permit insurers to charge lower premiums, on a sound financial basis. Lower premiums will encourage providers (particularly those in high-risk specialties) to offer healthcare services to Floridians, and persons visiting this state, and to do so at lower prices.

The Task Force respectfully finds and concludes that the proposed recommendations will provide a benefit to the citizens of the State of Florida. The Task Force is of the opinion that, while these comprehensive reforms are important, the centerpiece and the recommendation that will have the greatest long-term impact on healthcare provider liability insurance rates, and thus eliminate the crisis of availability and affordability of healthcare in Florida, is a $250,000 cap on non-economic damages. The Legislature should

commission and fund a study of the impact of the $250,000 cap on non-economic damages. An interim report should be submitted to the Legislature five years after date of enactment.

Chapter 1 - INTRODUCTION

"'The quality of medical care today is threatened by the pervasive, unwelcome, crushing embrace of the law. Every participant in the health care system is beset by an onslaught of new laws and regulations. Worst of all, because it is the most personal, physicians are forced to live with the specter of malpractice litigation constantly in their mind's eye. This legal assault has occurred so swiftly and has been implemented so harshly that it has begun to erase some of the very attractions long associated with pursuing a medical career—autonomy, independence, approbation, inquiry.' In sum, it is this peculiar combination of financial cost and psychological stress that has generated the passionate resentment that so many doctors feel toward the malpractice regime."

Paul C. Weiler, Medical Malpractice on Trial 7 (1991) (quoting Leon Rosenberg, Dean of the Yale Medical School)

The Governor's Select Task Force On Healthcare Professional Liability Insurance

Physicians and hospitals in Florida currently are experiencing a crisis in the availability and affordability of healthcare liability insurance. This crisis has adversely affected patient access to medical care in Florida.

Florida is among the states with the highest medical malpractice insurance premiums in the nation. This increase in healthcare liability insurance rates is forcing physicians to practice medicine without professional liability insurance, to leave Florida, to not perform high-risk procedures, or to retire early from the practice of medicine.

During the past three years, numerous healthcare liability insurance carriers in Florida have been liquidated, forced into rehabilitation, or have decided to stop selling medical malpractice insurance in Florida. Those companies that remain are quickly reaching capacity and are unable to expand their risk base to cover the physicians whose policies are being terminated by other companies. Recognizing this crisis existed, Governor Jeb Bush created a Task Force to study this crisis' effects and to offer solutions.

On August 28, 2002, Executive Order No. 02-241 created the Governor's Select Task Force on Healthcare Professional Liability Insurance (Task Force), which has the ultimate goal of "protecting Floridians' access to high-quality and affordable healthcare." Governor Jeb Bush directed the Task Force to:

- Examine Florida's healthcare liability insurance market, pertinent tort laws, claims, and premium data compared to other states of similar size and diversity;
- Assess the impact of the cost, accessibility, and availability of healthcare liability insurance on the cost, accessibility, and availability of high quality healthcare in this state;
- Examine specific strategies to ease the healthcare liability insurance crisis faced by Florida's physicians, hospitals and other healthcare providers; and
- Provide a written report and recommendations to the Governor, the President of the Senate, and the Speaker of the House of Representatives by January 31, 2003.