
# Medical Malpractice Caps

## The Impact of Non-Economic Damage Caps on Physician Premiums, Claims Payout Levels, and Availability of Coverage

by

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## The Impact of Non-Economic Damage Caps on Physician Premiums, Claims Payout Levels, and Availability of Coverage

**Executive Summary**

Soaring premiums on medical malpractice insurance ("med mal") are a national crisis, invading the practice of medicine, threatening the availability of care, and prompting widespread public outcry. Physicians and the insurance industry place the blame on out-of-control jury awards, and, in response, 19 states have implemented caps on non-economic damages—a key measure now included in various congressional proposals. However, the actual experience of the states with caps does not support these proposals. It shows that:

***Caps did reduce the burden on insurers...***

- In states with caps, the median payout between 1991 and 2002 was 15.7% lower than the median in states without caps, despite the fact that many states did not impose the caps until late in the 12-year period.
- Moreover, in states with caps, the payouts increased by 83.3% from 1991 to 2002, while the rate of increase in states without caps was 127.9%.

***But most insurers continued to increase premiums at a rapid pace, regardless of caps...***

- In states with caps, the median annual premium went up by 48.2%, but, surprisingly, in states *without* caps, the median annual premium increased at a *slower* clip—by 35.9%.
- Among the states with caps, only 10.5% experienced flat or declining med mal premiums. In contrast, among the states *without* caps, the record was actually *better*: 18.7% experienced flat or declining premiums.

***These counter-intuitive findings can lead to only one conclusion: There are other, far more important factors driving the rise in med mal premiums than caps or med mal payouts. These include:***

- The medical inflation rate. In the 12-year period through 2002, medical costs rose 75%.

- The insurance business cycle. The property and casualty industry as a whole suffered an unusually long 12-year "soft" period in the insurance business cycle through 1999, resulting in loose underwriting practices—not enough money in premiums collected to cover anticipated claims. At the end of the cycle, in an attempt to catch up, insurers began to tighten underwriting standards and raise premium rates.

- The need to shore up reserves. Med mal insurers have been consistently under-reserving since 1997—to the tune of $4.6 billion through December 31, 2001. The only way to shore up reserves is to increase premiums.

- A decline in investment income. With falling stock prices and declining interest rates, investment income for the entire property/casualty industry fell 23% in 2001 compared to 2000, and then *another* 2.5% in 2002. Moreover, investment income is particularly critical for lines of business like med mal where the duration of claims payouts typically spans several years.

- Financial safety. Based on the Weiss Safety Ratings, we find that 34.4% of the nation's med mal insurers are vulnerable to financial difficulties (those with a rating of D+ or lower), as compared to 23.9% of the property and casualty industry as a whole. In order to restore their financial health, many med mal insurers will remain under pressure to increase premiums despite new laws to cap payouts.

- Supply and demand. The number of med mal carriers increased until 1997, but has since fallen from 274 in that year to 247 in 2002. Moreover, in certain regions and medical specialties, there is evidence that some med mal insurers have pulled out or discontinued coverage.

Recommendations:

*Legislators* should put proposals involving non-economic damage caps on hold until convincing evidence can be produced to demonstrate a true benefit to doctors in the form of reduced med mal costs. *Regulators* must review and revise their parameters for approving rate increases. *Insurance companies* must never again allow marketing to divert or pervert prudent actuarial analysis and planning. The *medical profession* must assume more responsibility for policing itself, while states must be more pro-active in reviewing the licenses of individual practitioners. And *consumers* must not relinquish their right to sue for non-economic damages until the medical profession and/or state and federal governments provide more adequate supervision and regulation of doctors, hospitals, and other health care providers.

## Introduction

In the last few years, soaring premiums on medical malpractice insurance ("med mal") have emerged as a national crisis, invading the practice of medicine, threatening the availability of care, and prompting widespread public outcry.

Many doctors, particularly in high-risk specialties, have received renewal notices announcing premium increases of 100% or even 200% over the previous year. Others have simply been dropped by their insurance carriers, forcing them to shop for new med mal coverage, practice without any coverage at all, or stop practicing medicine altogether—all painful alternatives.

The insurance industry places the blame on out-of-control jury awards. In response, legislators in many states, accepting this argument at face value, have implemented tort reform to restrict awards in their states. Their primary vehicle: *Non-economic damage caps,* which limit the awards to an injured patient for intangible injuries, such as pain and suffering. Since 1975, 19 states have implemented these caps[1] at various levels ranging from $250,000 to $1 million, as follows:

| State | Cap ($) | Year Adopted |
|---|---|---|
| Alaska | 500,000 | 1997[2] |
| California | 250,000 | 1975 |
| Colorado | 250,000 | 1998 |
| Hawaii | 375,000 | 1976 |
| Idaho | 682,000 | 1990* |
| Indiana | 1,000,000 | 1990 |
| Kansas | 250,000 | 1994 |
| Louisiana | 500,000 | 1975 |
| Maryland | 805,000 | 1986* |
| Massachusetts | 500,000 | 1997 |
| Michigan | 624,000 | 1993* |
| Missouri | 547,000 | 1988* |
| Montana | 250,000 | 1997 |
| New Mexico | 600,000 | 1996 |
| North Dakota | 500,000 | 1996 |
| Utah | 250,000 | 1996 |
| Virginia | 1,000,000 | 1992 |
| West Virginia | 1,000,000 | 1986 |
| Wisconsin | 350,000 | 1995*[3] |

*Caps are adjusted annually for inflation.

[1] The implementation of caps on non-economic damages has no impact on jury awards for actual damages such as medical expenses and loss of income.

[2] Applies to incidents occurring before August 1997. After August 1997: the cap is the greater of $400,000 or life expectancy times $8,000 except in the case of severe disfigurement or physical impairment in which the cap is the greater of $1 million or life expectancy times $25,000.

[3] Applies to damages from all health care providers except in wrongful death cases. Damages in wrongful death are limited to $500,000 for the death of a minor and $350,000 for the death of an adult.

Now, in an attempt to cope with the emerging med mal crisis, the push to impose caps has reached the federal level, with a number of legislative proposals to institute reforms, usually including, as the most salient feature, a $250,000 nationwide cap.

This white paper is not driven by a political ideology or industry-driven self-interest. It is, rather, an objective, data-driven analysis of:

- the real relationship between caps and med mal premiums (Part 1)
- other forces behind rising premium rates (Part 2)
- lessons to be learned from the crisis along with effective long-term solutions (Part 3).

## Part 1. The Real Relationship between Caps and Med Mal Premiums

On the surface, the theory behind caps on non-economic damage awards seems logical: caps would limit the payouts by insurers, and the lower payouts, in turn, would naturally enable the insurers to reduce med mal premiums. As we shall demonstrate below, however, in the real world of the med mal insurance business, only the first half of this theory is working.

***Caps do reduce the burden on insurers...***

Using data provided by the National Practitioner Data Bank, we compared the median payouts in the 19 states with caps to those in the 32 states without caps[4] for the period between 1991 and 2002, with the following results:

- **Payouts reduced.** In states without caps, the median payout for the entire 12-year period was $116,297, ranging from $75,000 on the low end to $220,000 on the high end. In states with caps, the median was 15.7% lower, or $98,079, ranging from $50,000 to $190,000.[5] Since caps in many states were not imposed until late in the 12-year period, this represents a significant reduction.

- **Growth in payouts slowed substantially.** The median payout in the 32 states without caps increased by 127.9%, from $65,831 in 1991 to $150,000 in 2002. In contrast, payouts in the 19 states with caps increased at a far slower pace—by 83.3%, from $60,000 in 1991 to $110,000 in 2002.

In short, it's clear that caps do accomplish their intended purpose of lowering the average amount insurance companies must pay out to satisfy med mal claims.

***But insurers continue to increase premiums at a rapid pace, regardless of caps.***

Using 1991 to 2002 data published by the Medical Liability Monitor, we examined the median med mal premiums paid by doctors in three high-risk specialties—internal medicine, general surgery, and obstetrics/gynecology. The results:

1. **States with caps had sharper increases in median annual premiums.** Since the insurers in the states with caps reaped the benefit of lower med mal payouts, one would expect that they'd reduce the premiums they charged doctors. At the very minimum, they should have been able to slow down the rate of premium increases. Surprisingly, the data show they did precisely the opposite:

    - In the 19 states with caps, the median annual premium increased by 48.2%, from $20,414 in 1991 to $30,246 in 2002.

[4] For the purposes of this analysis, the District of Columbia is being referred to as a "state" since it effectively operates as such with regard to insurance regulation.
[5] Adjusted for inflation in order to evaluate figures spanning multiple years.

- In the 32 states *without* caps, the median annual premium actually increased at a *slower* pace—by 35.9%, from $22,118 in 1991 to $30,056 in 2002.

Thus, on average, *doctors in states with caps actually suffered a significantly larger increase than doctors in states without caps.*

2. **A smaller proportion of states with caps were able to contain premium increases.** In some states, the median annual premiums remained flat or even declined at various times during the period. Was *this* related to the imposition of caps? In the overwhelming majority of states, the answer is clearly "no." Indeed...

   - Among the 19 with caps, only two states, or 10.5%, experienced flat or declining med mal premiums following the imposition of caps.

   - Meanwhile, among the 32 without caps, the record was actually much better: Six states, or 18.7%, experienced flat or declining premiums.

3. **Premiums in states with caps are more likely to exceed national median.** Focusing on the most recent data, we find that:

   - In 47.4% of the states with caps (9 out of 19), 2002 median premiums were below the national median premium of $30,093.

   - Meanwhile, in 50% of the states without caps (16 out of 32), 2002 median premiums were *below* the national median.

In short, the results clearly invalidate the expectations of cap proponents. To review the surprising facts:

- Insurers in states with caps raised their premiums at a significantly faster pace than those in states without caps.

- Even with the imposition of caps, insurers in nearly nine out of ten states continued to raise rates, while insurers in states without caps were actually *more* likely to hold or cut their premium rates.

- In states with caps, insurers are more likely to charge med mal premiums exceeding the national median than those in states without caps.

These counter-intuitive findings can lead to only one conclusion: There are other, far more important factors driving the rise in med mal premiums than caps or med mal payouts, the subject of the next section.

## Part 2. Other Factors Driving Up Med Mal Premiums

We have identified six factors driving up premiums, each of which may be exerting a greater impact on premiums than the presence or absence of caps. These are (1) medical cost inflation, (2) the cyclical nature of the insurance market, (3) the need to shore up reserves for policies in force, (4) a decline in investment income, (5) overall financial safety considerations, and (6) the supply and demand of coverage. We examine each of these factors below.

### 1. Medical Cost Inflation

The medical inflation rate in the 12-year period was 75%[6] (i.e., $1 of medical expenses in 1991 cost $1.75 in 2002). However, throughout the country, insurers had a general tendency to let their premium increases lag behind the pace of medical inflation. This was most likely due to the extended soft market experienced by the entire property and casualty insurance industry in the 1990s, explained below.

### 2. The Cyclical Nature of the Insurance Market

The market for property/casualty insurance, including med mal, is historically and fundamentally cyclical, with periods of rising premium rates followed by periods of steady or declining premiums. In the declining portion of the cycle—"a soft market"—insurers relax their underwriting standards and underprice their products in order to retain or gain market share.

The most recent soft market lasted longer than usual—12 years, from 1987 to 1999—probably because of the raging bull market in stocks. Insurers made so much money in their investments they were able to aggressively underprice their policies, deliberately lose money in their underwriting, and still turn a profit overall. As a result, losses in their core operations, more than offset by surging gains from the stock market boom, were largely overlooked by the industry and regulators alike.

All that changed when the stock market boom turned to bust. Property and casualty insurers had to confront the ramifications of their loose underwriting practices: not enough money in premiums collected to cover anticipated claims. That's when they began to seriously tighten underwriting standards and raise premium rates.

### 3. The Need to Shore Up Reserves for Policies in Force

When insurers write a new policy, they look at past claims experience, make some actuarial assumptions, and place a portion of that policy's premium into a reserve to cover expected future claims. A prudent insurer will make conservative assumptions and err on the side of having more in reserve than it ultimately needs to pay claims. At the end of each year, the insurer then evaluates its reserves for each block of business and determines if a change is warranted to either add or subtract reserves.

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[6] Medical inflation rate: 1991: 8.7%, 1992: 7.4%, 1993: 5.9%, 1994: 4.8%, 1995: 4.5%, 1996: 3.5%, 1997: 2.8%, 1998: 3.2%, 1999: 3.5%, 2000: 4.1%, 2001: 4.6%, 2002: 4.7%.

Data reported to the National Association of Insurance Commissioners (NAIC) show that med mal insurers have been consistently under-reserving since 1997—to the tune of $4.6 billion through December 31, 2001. The under-reserving came to a head in 1999, at the tail end of the soft market. That's when loose underwriting practices caught up with the insurers, as claims rose to a higher level than expected. Thus, even before the bull market ended in the stock market, insurers were coming under increasing pressure to boost their reserves to make up for past shortfalls.

There's only one place these funds could come from—the company's capital; and there was only one way the company could maintain or build its capital—by making more profits. Thus, premium increases were inevitable.

**4. A decline in investment income**

Until 2000, most of the additional profits insurers needed could be covered by rising investment income and gains from the booming stock market. But during the three-year bear market from 2000 to 2002, as large stock market gains turned to even larger stock market losses, insurers were confronted with double trouble:

- After just one year of premium increases, they still had barely begun to restore their reserves.

- Now, aggravating their difficulties, they also needed to compensate for stock market losses. With falling stock prices and declining interest rates, investment income[7] for the entire property/casualty industry fell 23% in 2001 compared to 2000, and then *another* 2.5% in 2002; and we must assume that med mal insurers suffered a similar decline. Indeed, investment income is particularly critical for lines of business like med mal where the duration of claims payouts typically span several years.

Thus, it was the combination of two powerful forces—under-reserving throughout most of the 1990s *plus* the rapid fall in investment income in the 2000s—that largely drove the unusually rapid premium increases, not only in med mal, but in many other property and casualty lines as well.

**5. Financial Safety**

If insurers do not replace capital that has been used to shore up reserves, the financial strength of the company deteriorates, ultimately leading to the possibility of financial failure.

The Weiss Safety Ratings measure an insurer's overall financial strength based on evaluations of its capitalization, reserve adequacy, profitability, liquidity, and stability. Among the 2,851 property and casualty insurers reporting to the NAIC, 247 companies wrote at least some med mal policies in 2002, with 90 of these deriving at least 50% of their total premiums from the med mal sector.

[7] Investment income is defined as capital gains plus interest income.

Within this group of 90, which we define as "med mal insurers," there were a higher-than-average number of vulnerable companies, as compared to the property and casualty industry as a whole (Table 1).

Table 1. Safety of Insurers: Med Mal vs. All Property and Casualty Insurers

| Weiss Safety Rating Category | 2003 All P&C Insurers | 2003 Med Mal Insurers |
|---|---|---|
| Secure | 76.1% | 65.5% |
| Vulnerable | 23.9% | 34.4% |

"Secure" includes companies rated **A** (Excellent), **B** (Good), and **C** (Fair).
"Vulnerable" includes those rated **D** (Weak) and **E** (Very Weak)

What progress have med mal insurers made in restoring their financial health by raising premiums? So far, none: Despite higher premiums since 1999, there has been no improvement in the financial safety of the med mal insurers. Quite to the contrary, the proportion of insurers in the "vulnerable" category has increased since 1999 (Table 2).

Table 2. Safety of Med Mal Insurers: 2003 vs. 1999

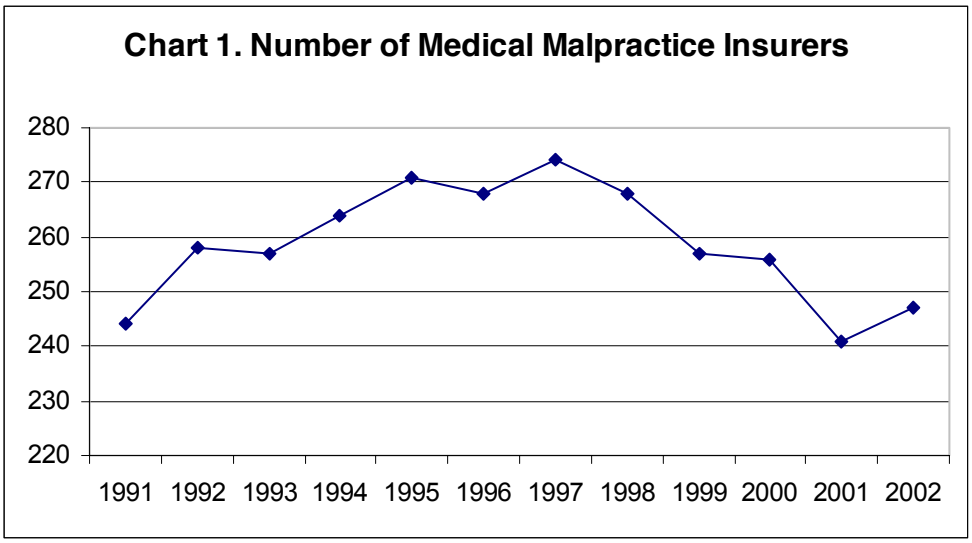
| Weiss Safety Rating Category | 2003 Med Mal Insurers | 1999 Med Mal Insurers |
|---|---|---|
| Secure | 65.5% | 69.0% |
| Vulnerable | 34.4% | 31.0% |

Thus, in order to restore their financial health, *many med mal insurers will remain under pressure to continue to increase premiums despite any new laws that are enacted to cap individual payouts.*

## 6. The Supply and Demand of Coverage

Press reports have highlighted the plight of physicians around the country who are closing up shop because their med mal insurer is pulling out of the local market.

To help determine if this is an industry-wide problem, for each year between 1991 and 2002, we counted the number of insurers that are writing new med mal policies and/or renewing existing policies (Chart 1).




The number of carriers providing med mal coverage nationwide increased from 244 in 1991 to a peak of 274 in 1997. Since 1997, however, the number of carriers declined steadily to a low of 241 in 2001, recovering slightly to 247 in 2002.

Compared to 1991, therefore, there has actually been a modest *increase* in the number of med mal carriers—from 244 to 247.

However, doctors are currently feeling the pressures of diminished supply reflected in the declining trend since 1997. Moreover, in certain regions and in certain medical specialties, there is abundant anecdotal evidence that certain med mal insurers have pulled out or discontinued coverage.

## Part 3. Conclusions and Recommendations

There is no doubt that the implementation of non-economic damage caps has resulted in lower claim payouts for insurers. For caps to be considered successful, however, the lower payouts would need to translate into lower med mal premiums for medical professionals. Unfortunately, that has not been the case due to the continuing presence of other, far more significant factors driving premium rates higher.

Indeed, the 1991 to 2002 data indicate that the presence of caps may be *inversely correlated* to med mal premium levels. We have no data to pinpoint the reasons for this perverse result and therefore can only speculate as to what they may be. Some possibilities include:

- Legislatures in states with a preponderance of unprofitable med mal insurers may have been among those that were most pressured by those insurers and their lobbyists to impose caps. Meanwhile, states that have not imposed caps so far may be those in which med mal insurers were relatively less desperate to begin with. Insurers in states with caps may have *already* been on the path toward faster rate increases even before the caps were legislated, and the changes in the legislation may have merely been a symptom of—not an impediment to—this trend.

- Once caps were imposed, regulators in those states may have been somewhat more liberal in allowing rate increases, making the false assumption that caps alone would sooner or later help to correct the imbalances in the marketplace.

Furthermore, med mal insurers have also had to deal with the added burden of high medical inflation, which directly impacts their claims experience. By the end of the soft market in 2000, these insurers found themselves in a position where claims costs had increased, but premium income had not even kept pace with inflation.

All of these forces led to an inevitable increase in the med mal premiums insurers charge to doctors and other medical professionals. But despite the increase in revenue, the med mal insurers as an industry have continued to weaken financially and remain weaker than the overall property/casualty insurance industry.

In summary, we believe the broad market forces prevailing in the property/casualty industry have driven—and continue to drive—med mal premiums up, evidently overwhelming any reduction in jury awards.

Thus, by focusing on caps as a solution...

- The insurance companies and their supporters are diverting the public's attention away from long years of mismanagement by an industry that continually allowed actuarial prudence to take a back seat to marketing strategy.

- The insurers, insurance regulators and insurance legislators are avoiding a much-needed post-mortem on what really went wrong in the property and casualty industry

in general and in the med mal sector in particular. Was it prudent to rely so heavily on investment income while underwriting income stayed chronically in the red? Did industry decision makers get caught up in the stock market euphoria like nearly everyone else?

- Worst of all, many companies and legislators are using the insurance crisis opportunistically to push tort reform. However, tort reform, to be productive, merits more pondered and balanced debate based on its own merits, independent of the insurance crisis.

We recommend the following steps:

**First, *legislators* must immediately put on hold all proposals involving non-economic damage caps until convincing evidence can be produced to demonstrate a true benefit to doctors in the form of reduced med mal costs.** Right now, consumers are being asked to sacrifice not only large damage claims, but also critical leverage to help regulate the medical profession—all with the stated goal that it will end the med mal crisis for doctors. However, the data indicate that, similar state legislation has merely produced the worst of both worlds: The sacrifice by consumers *plus* a continuing—and even worsening—crisis for doctors. Neither party derived any benefit whatsoever from the caps.

**Second, *regulators* must review and revise their parameters for approving rate increases.** The big lesson to be learned from the past decade is that it's dangerous to count on volatile investments—especially common stocks—to compensate for poor operations.

For many years, we have warned that rather than evaluating the property and casualty business based on total profits (including investment income), the focus should be on underwriting profits and losses, independent of investment income.[8] Had our warnings been heeded, premium rate increases may have risen gradually over time, rather than jumping suddenly during an already-painful bear market.

**Third, *insurance companies* must never again allow marketing to divert or pervert prudent actuarial analysis and planning.** Consumers and medical professionals can accept rate increases provided they are spread out evenly over time, and provided they are given good value for their premium dollars in terms of claims paying ability and stability. They cannot accept rate increases that are designed to cover up, or compensate for, serious mismanagement.

**Fourth, *the medical profession* must assume more responsibility for policing itself, while states must be more pro-active in reviewing the licenses of individual practitioners who have a significantly higher-than-average number of claims against them in their specialty, in proportion to their level of activity.** These individuals

[8] "Property & Casualty Insurers Cashing in on Wall Street Windfalls to Offset Underwriting Losses," February 28, 1997. "Property and Casualty Insurers Suffer 40% Decline in Net Income in 1994," April 18, 1995.

greatly increase the risk associated with their specialties, pushing med mal premiums up for all doctors in that sector. States must also make major strides to share data on high-risk doctors. At the very minimum, they must cease licensing doctors who have lost their licenses in other states, often due to high-cost medical mistakes.

**Fifth, *consumers* must not relinquish their right to sue for non-economic damages until the medical profession and/or state and federal governments provide more adequate supervision and regulation of doctors, hospitals, and other health care providers.**

The imposition of caps will not make a significant dent in the problem, and may even have adverse impacts. It is no substitute for longer-term, fundamental solutions that address the actual factors behind the med mal crisis.

# Appendix 1

## States with Caps:
## Median Medical Malpractice Payouts/Premiums 1991 - 2002

| State | Year Imposed | Amount of Cap ($000) | 1991 Median Payout ($) | 2002 Median Payout ($) | % Change 1991 to 2002 | 1991 Median Premium ($) | 2002 Median Premium ($) | % Change 1991 to 2002 |
|---|---|---|---|---|---|---|---|---|
| Alaska | 1997 | 500 | 125,000 | 165,000 | 32.0 | N/A | 27,940 | N/A |
| California | 1975 | 250 | 31,700 | 67,500 | 112.9 | 20,354 | 30,430 | 49.5 |
| Colorado | 1998 | 250 | 25,000 | 100,000 | 300.0 | 22,678 | 33,651 | 48.4 |
| Hawaii | 1976 | 375 | 30,000 | 250,000 | 733.3 | 23,334 | 25,756 | 10.4 |
| Idaho | 1990 | 682 | 22,000 | 100,000 | 354.5 | N/A | 14,199 | N/A |
| Indiana | 1990 | 1,000 | 35,000 | 50,000 | 42.9 | N/A | 22,886 | N/A |
| Kansas | 1994 | 250 | 75,000 | 103,765 | 38.4 | 14,669 | 23,335 | 59.1 |
| Louisiana | 1975 | 500 | 65,000 | 100,000 | 53.8 | 20,291 | 37,280 | 83.7 |
| Maryland | 1986 | 605 | 75,000 | 180,000 | 140.0 | 24,193 | 34,771 | 43.7 |
| Massachusetts | 1997 | 500 | 100,000 | 250,000 | 150.0 | N/A | 30,246 | N/A |
| Michigan | 1993 | 624 | 60,000 | 77,000 | 28.3 | 65,946 | 68,225 | 3.5 |
| Missouri | 1988 | 547 | 80,000 | 162,500 | 103.1 | 25,999 | 38,759 | 49.1 |
| Montana | 1997 | 250 | 30,000 | 100,000 | 233.3 | 18,697 | 27,011 | 44.5 |
| New Mexico | 1996 | 600 | 100,000 | 110,000 | 10.0 | N/A | 67,161 | N/A |
| North Dakota | 1996 | 500 | 57,500 | 75,000 | 30.4 | N/A | 16,238 | N/A |
| Utah | 1996 | 250 | 20,000 | 115,000 | 475.0 | 20,474 | 37,290 | 82.1 |
| Virginia | 1992 | 1,000 | 50,000 | 200,000 | 300.0 | 16,497 | 21,343 | 29.4 |
| West Virginia | 1986 | 1,000 | 100,000 | 140,465 | 40.5 | N/A | 56,989 | N/A |
| Wisconsin | 1995 | 350 | 90,000 | 256,357 | 184.8 | 18,111 | 17,213 | -5.0 |
| Total | | | 60,000 | 110,000 | 83.3 | 20,414 | 30,246 | 48.2 |

Source: Compiled and analyzed by Weiss Ratings, Inc. from data supplied by Medical Liability Monitor and the National Practitioners Data Bank

# Appendix 2

## States without Caps:
## Median Medical Malpractice Payouts/Premiums 1991 - 2002

| State | 1991 Median Payout ($) | 2002 Median Payout ($) | % Change 1991 to 2002 | 1991 Median Premium ($) | 2002 Median Premium ($) | % Change 1991 to 2002 |
|---|---|---|---|---|---|---|
| Alabama | 75,000 | 200,000 | 166.7 | 25,629 | 23,490 | -8.3 |
| Arizona | 66,875 | 169,240 | 153.1 | 37,601 | 38,571 | 2.6 |
| Arkansas | 72,495 | 125,000 | 72.4 | 10,422 | 16,384 | 57.2 |
| Connecticut | 66,663 | 250,000 | 275.0 | 29,198 | 40,146 | 37.5 |
| Delaware | 73,539 | 150,000 | 104.0 | N/A | 24,731 | N/A |
| District of Columbia | 172,000 | 162,500 | -5.5 | 28,085 | 40,871 | 45.5 |
| Florida | 95,000 | 162,500 | 71.1 | 43,600 | 95,474 | 119.0 |
| Georgia | 75,000 | 175,000 | 133.3 | 27,998 | 30,093 | 7.5 |
| Illinois | 115,000 | 320,000 | 178.3 | 39,260 | 49,948 | 27.2 |
| Iowa | 41,250 | 102,500 | 148.5 | 21,140 | 18,607 | -12.0 |
| Kentucky | 48,258 | 49,000 | 1.5 | 23,666 | 44,834 | 89.4 |
| Maine | 75,000 | 250,000 | 233.3 | 22,118 | 18,583 | -16.0 |
| Minnesota | 45,000 | 125,000 | 177.8 | 8,117 | 10,142 | 25.0 |
| Mississippi | 45,000 | 131,500 | 192.2 | 19,726 | 30,871 | 56.5 |
| Nebraska | 39,000 | 131,250 | 275.0 | N/A | 14,710 | N/A |
| Nevada | 32,500 | 175,000 | 438.5 | 24,988 | 59,776 | 139.2 |
| New Hampshire | 50,000 | 250,000 | 400.0 | N/A | 27,157 | N/A |
| New Jersey | 75,000 | 210,000 | 180.0 | 20,162 | 38,307 | 90.0 |
| New York | 75,000 | 200,000 | 166.7 | 48,026 | 50,970 | 6.1 |
| North Carolina | 72,000 | 195,000 | 170.8 | 11,294 | 31,687 | 180.6 |
| Ohio | 24,667 | 137,500 | 457.4 | 31,450 | 52,764 | 67.8 |
| Oklahoma | 50,000 | 97,000 | 94.0 | 9,137 | 12,766 | 39.7 |
| Oregon | 65,000 | 95,000 | 46.2 | 17,268 | 26,711 | 54.7 |
| Pennsylvania | 100,000 | 200,000 | 100.0 | 11,433 | 71,260 | 523.3 |
| Rhode Island | 62,500 | 125,000 | 100.0 | N/A | 27,922 | N/A |
| South Carolina | 59,475 | 100,000 | 68.1 | 12,984 | 21,337 | 64.3 |
| South Dakota | 25,000 | 150,000 | 500.0 | 9,618 | 13,853 | 44.0 |
| Tennessee | 58,750 | 110,000 | 87.2 | 15,601 | 30,018 | 92.4 |
| Texas | 70,347 | 150,000 | 113.2 | 27,945 | 55,951 | 100.2 |
| Vermont | 42,500 | 40,865 | -3.8 | N/A | 15,690 | N/A |
| Washington | 40,000 | 150,000 | 275.0 | 18,158 | 23,100 | 27.2 |
| Wyoming | 80,000 | 125,000 | 56.3 | 22,758 | 39,829 | 75.0 |
| Total | 65,831 | 150,000 | 127.9 | 22,118 | 30,056 | 35.9 |

Source: Compiled and analyzed by Weiss Ratings, Inc. from data supplied by Medical Liability Monitor and the National Practitioners Data Bank

# Appendix 3

## Weakest Medical Malpractice Insurers

| Company | 2002 Total Med Mal Premium ($000) | 2002 Total Premium ($000) | Weiss Safety Rating |
|---|---|---|---|
| Academic Health Professionals Insurance | 16,484 | 16,484 | E |
| American Association of Orthodontist RRG | 4,505 | 4,506 | D |
| American Excess Insurance Exchange RRG | 33,682 | 39,747 | E |
| American Physicians Assurance | 170,440 | 230,224 | D |
| American Physicians Insurance Exchange | 34,887 | 34,887 | D |
| Campmed Casualty & Indemnity of MD | 3,750 | 7,237 | E+ |
| Commonwealth Medical Liability Insurance | 29,648 | 29,893 | D+ |
| Delaware Professional Insurance | 732 | 732 | E+ |
| Eastern Dentists Insurance RRG | 6,961 | 7,314 | D |
| Franklin Casualty Insurance RRG | 19,377 | 19,377 | D- |
| Hanys Insurance | 74,529 | 76,260 | D+ |
| Hospital Casualty | 22,637 | 26,112 | E |
| Hospital Underwriting Group | 22,620 | 22,776 | E |
| Lion Insurance | 51 | 86 | D+ |
| MCIC Vermont RRG | 155,021 | 162,325 | D |
| MedAmerica Mutual RRG | 7,838 | 7,838 | D+ |
| National Guardian RRG | 7,422 | 7,422 | E |
| New England Medical Center of VT | 1,166 | 1,166 | D- |
| Northwest Physicians Mutual Insurance | 33,094 | 33,200 | D+ |
| OHIC Insurance | 136,926 | 151,597 | D |
| PACO Assurance | 3,171 | 3,172 | D+ |
| Physicians Liability Insurance | 40,626 | 75,071 | E+ |
| Physicians Reciprocal Insurers | 185,333 | 186,924 | E+ |
| Physicians Reimbursement Fund | 2,193 | 2,193 | E+ |
| Preferred Physicians Medical RRG | 24,906 | 24,905 | D+ |
| Princeton Insurance | 240,266 | 374,811 | D |
| SCPIE Indemnity | 100,198 | 101,675 | D+ |
| Texas Hospital Insurance Exchange | 7,304 | 14,009 | D- |
| Tri Century Insurance | 24,238 | 24,238 | D+ |
| VHA Risk Retention Group | 29,071 | 30,616 | D- |
| Virginia Health Systems Alliance | 12,058 | 12,242 | E |

A = Excellent; B = Good; C = Fair; D = Weak; E = Very Weak

Source: Weiss Ratings, Inc.

# Appendix 4

## Other Studies and Position Statements published by Participants in this Debate


"Florida's Medical Malpractice Insurance Crisis: An Examination of Strategic Public Policy Issues." The Florida Center for Public Policy and Leadership at the University of North Florida. March 2003. This study is currently being updated, but will be available at http://www.unf.edu/thefloridacenter/press_room/index.shtml when complete.

"Hype Outraces Rates in Malpractice Debate; Degree of Crisis Varies Among Specialties and From State to State." *USA Today*. March 4, 2003.
http://www.usatoday.com/news/nation/2003-03-04-malpractice-cover_x.htm

"Medical Malpractice Analysis." Milliman USA on behalf of Florida Hospital Association. November 7, 2002.
http://heal-fl-health-care-pdf.netcomsus.com/resources_MillimanUSAstudy.pdf

"Medical Malpractice Insurance: Stable Losses/Unstable Rates." Americans for Insurance Reform. October 10, 2002.
http://www.insurance-reform.org/StableLosses.pdf

"Medical Malpractice: Questions and Answers." American Trial Lawyers Association.
http://www.atla.org/ConsumerMediaResources/Tier3/press_room/FACTS/medmal/icqanda.aspx

"Premium Deceit: The Failure of 'Tort Reform' to Cut Insurance Prices." Center for Justice & Democracy. July 29, 1999; reissued February 12, 2002.
http://www.insurance-reform.org/PremiumDeceit.pdf.

"President's Medical Malpractice Plan Based on Biased, Inaccurate Information; CFA Identifies Insurer Practices as Cause of Soaring Rates." Consumer Federation of America. July 31, 2002.
http://www.consumerfed.org/073102medmalrelease.html.

"Update on the Medical Litigation Crisis: Note the Result of the 'Insurance Cycle'." U.S. Department of Health and Human Services, Office of Disability, Aging and Long-Term Care Policy. September 25, 2002.
http://www.aspe.hhs.gov/daltcp/reports/mlupd2.htm.

Statement by the Physician Insurers Association of America. January 29, 2003.
http://www.thepiaa.org/publications/pdf_files/January_29_Piaa_Statement.pdf.