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Wyoming Healthcare Commission

Presentation of Melissa S. Denison
Director of Business Development
OHIC Insurance Company, Columbus, OH
July 28, 2003

Members of the Wyoming Healthcare Commission, good afternoon. I am Melissa Denison of OHIC Insurance Company headquartered in Columbus, OH.

OHIC was formed in 1978 by the Ohio Hospital Association to serve the medical liability needs of its members, which it has done for almost 25 years. In 1997 largely in response to the impending failure of PIE, Ohio's largest writer of physician liability, OHIC began to insure physicians. Taking on this additional responsibility required significant capital and today we are a subsidiary of the largest physician owned Medical Liability company in the United States, MLMIC. Today the medical liability marketplace is highly fragmented with 75% of the business written by small state and regional companies. As evidenced by St. Paul's departure, large, national companies have no interest in providing insurance to doctors and hospitals. Medical Malpractice Insurance only represents 3% of the Property Casualty Insurance Industry. The large national companies no longer are interested in this line of insurance.

OHIC began writing professional liability in Wyoming in 1985 when other carriers were exiting or downsizing in the state. Based upon the 2001 Best State Line Report, OHIC is the largest writer of medical liability in Wyoming. We currently insure 262 physicians, 10 hospitals and various other healthcare institutions.

Those that profess that Tort Reform is a windfall for the insurance industry are misinformed. Insurance spreads the losses of the few over a large base of insureds. Tort Reform measures will reduce the total losses that will eventually be spread over the insured physicians and hospitals in the state. The lower the level of total losses in the state, the lower the premium level needed in the state. I have attached a report that was done by the American Academy of Actuaries that contrasts the results of Tort Reform efforts.

For those who want evidence that Caps on non-economic damages keep rates down, you only need to look at the filed rates in Wyoming against other states and see that today an OB/GYN pays more for medical liability coverage in Wyoming than an OB/GYN in northern California or twice as much as an OB/GYN in Wisconsin. See Table 5 and 6 from the HHS report labeled as Exhibits "A" and "B-1"and a copy of OHIC's rates for various physician specialties in our key states labeled as Exhibit "B2". I have also included our bed rates in our key states as Exhibit "B-3".

Caps have no correlation to an insurer's margin of profit. The number of competitors in a market does. Caps do provide for more stability and increased predictability and will have a direct impact on the loss costs and rate level of the state. A stable and predictable environment will be attractive to new capital and will bring more competitors back into the state. The increased competition will force margins down to their appropriate level.

In Wyoming we must file all rate changes (+ or-) with the Wyoming Department of Insurance and are not permitted to use them until we receive prior approval. The components of rate making are losses, loss adjustment expenses, administrative costs and profit. Included in rate making is an investment return assumption as well. Rates are approved on a prospective basis and there is no allowance to recoup prior years losses.

What continues to impact defense costs are defending a large percentage of claims that are without merit. Approximately 75-80% of our claims result in no payment to a plaintiff. Another item that has driven up costs lately is our being forced to take more cases to trial due to unrealistic and unjustified demands.

In frustration some have suggested that Insurance Companies are raising rates to make up for losses in the stock market. This is simply not true. For the last 5 years Medical Malpractice Specialty companies, such as ours, have held only 10-12% of their invested assets in stocks. Our investment income as a percentage of our earned premiums has been fairly steady at 22% for the last 3 years although down from a high of 30% in 1998. See Exhibit "C" which shows the change in our Combined Ratio vs. the change in our investment return ratio.

The true culprit has been the sudden dramatic rise in loss severity (the average paid per claim). The most recent 5 years show a 13% annual

increase, the last 3 years a dramatic 21% increase. Our average cost per claim went from $88,000 in 1995 to $237,000 in 2001.These are actual numbers taken from the final settlement when we settle a claim. There has not been a change in the number of claims we receive, there has not been a change in the percentage of claims we close with no indemnity payment. This 13-21% rise in severity is far greater than the 5% that most companies projected when they were setting their rates in the mid-nineties.

Some argue that this is just an insurance "cycle". If that were true then all states would be experiencing the same problem. That is not the case. States with reforms are not experiencing the crisis. (Again refer to Exhibit "A")

Caps on non-economic damages are the centerpiece of effective Tort Reform because they provide clear parameters for compensating parties rather than leaving it up to the present day lottery mentality. In July 2002, the U.S. Department of Health and Human Services made the following statements with respect to non-economic damages: "... the present system gives juries a blank check to award huge damages based on sympathy, attractiveness of the plaintiff and the plaintiff's socio-economic status"..."the theories on which these awards are made however, are entirely subjective and without any standards" Quoting scholar Paul Weiler, who authored "Medical Malpractice on Trial" in 1991, "...the perceived problem of pain and suffering awards is not simply the amount of money expended, but also the erratic nature of the process by which the size of the awards is determined."

While having a cap is better than what we have today, I would ask you to consider what problem you are trying to solve in establishing the dollar threshold of the cap. If you are attempting to prevent the outlandish monumental awards that have occurred in some states such as Pennsylvania and try to keep the market from deteriorating further, then a cap that can go as high as a $1 Million will suffice. However, if your objective is to introduce legislation that will have an impact on rates, the Cap needs to be in the $250,000 to $500,000 range. Once you cross over the $500,000 level, the impact on rates diminishes. The only state that I am familiar with that had a cap as high as $1 Million is West Virginia, and that has not proven to be effective. Caps have been misrepresented in the press and I have included an example of how the cap worked on a case we had in Wisconsin. See Exhibit "E".

A limit on attorney's fees is another valuable feature. We have seen the benefit of this provision even in liberal jurisdictions such as Illinois and New York. More money goes to the injured party and lawyers do not have the incentive to go for the "home run" case.

Another important component is the collateral source rule. If our goal is to have a system that is fair and compensates individuals for what they have lost, then it is unfair to enable people to collect for damages for which they have already been compensated. It has been suggested that allowing collateral sources or offsets would drive up benefits costs. This is not true. In the present system the costs are already being covered by the benefits system and again by the litigation process. Living trusts are established to protect awards from being offset by Medicare or Medicaid. I thought our goal was to make the injured party "whole" not "see how much money they can get". This double indemnity capability furthers the lottery mentality and undermines fairness.

We also support periodic payments. Since a large part of the awarded damages are for future costs, then annuities that guarantee that future money will be there to satisfy future needs serve public policy. Escalation factors are used to establish damages for future income. In effect we are being asked to pay that future amount in today's dollars, which is a further enrichment for the few. Paying what is needed today in today's dollars and providing an annuity for the future needs is both fair but also prudent.

Ultimately we want to continue to be a valued partner to the Wyoming healthcare community; the present system is not a level playing field. It is the equivalent of gambling with a deck stacked against you. I urge you to take leadership position and take positive steps to address litigation concerns and level the playing field.

Fall
1996

ISSUE BRIEF

Medical Malpractice Tort Reform: Lessons from the States

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

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

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

Findings

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

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

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

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• **California.** Since the Medical Injury Compensation Reform Act (MICRA) package of reforms was enacted in 1975, medical malpractice costs have fallen substantially as a percentage of the U.S. total.

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

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

California

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

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

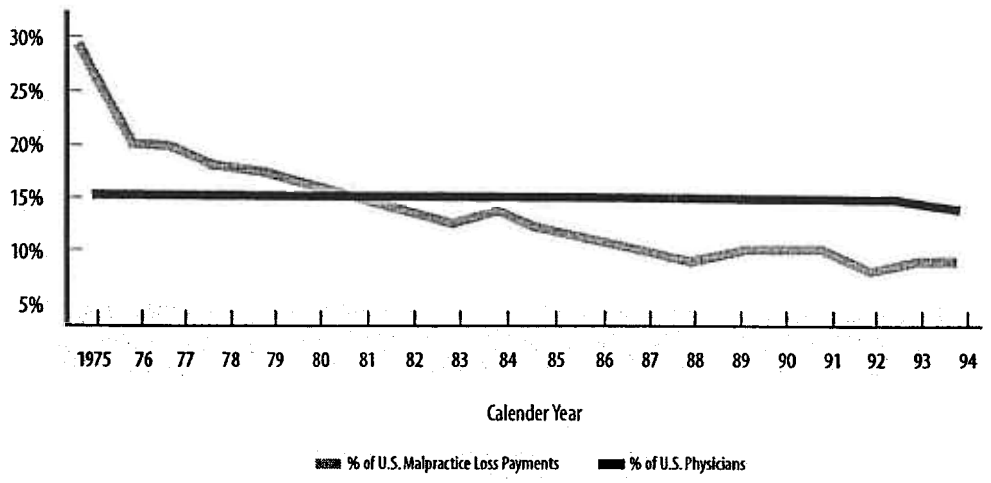
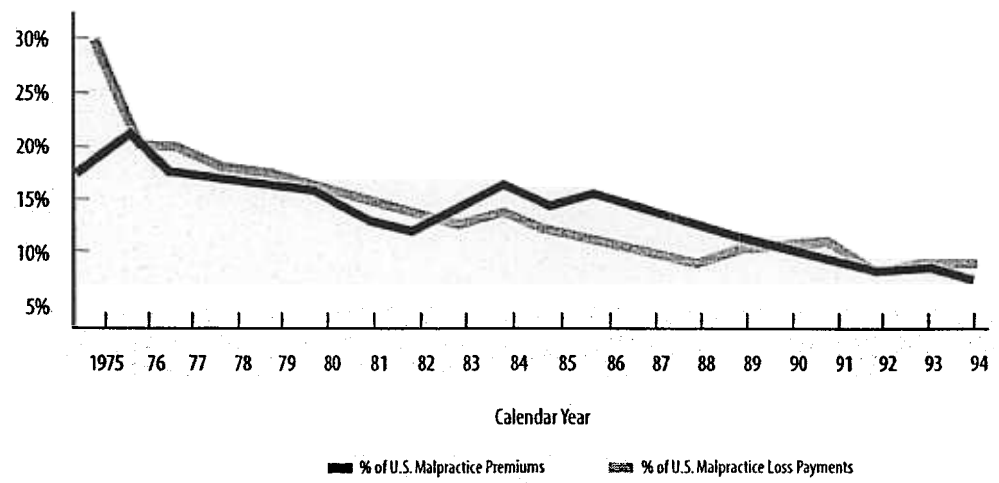


Exhibit 2
Malpractice Premiums and Malpractice Loss Payments in California as a Percentage of the U.S. Total, 1975–94



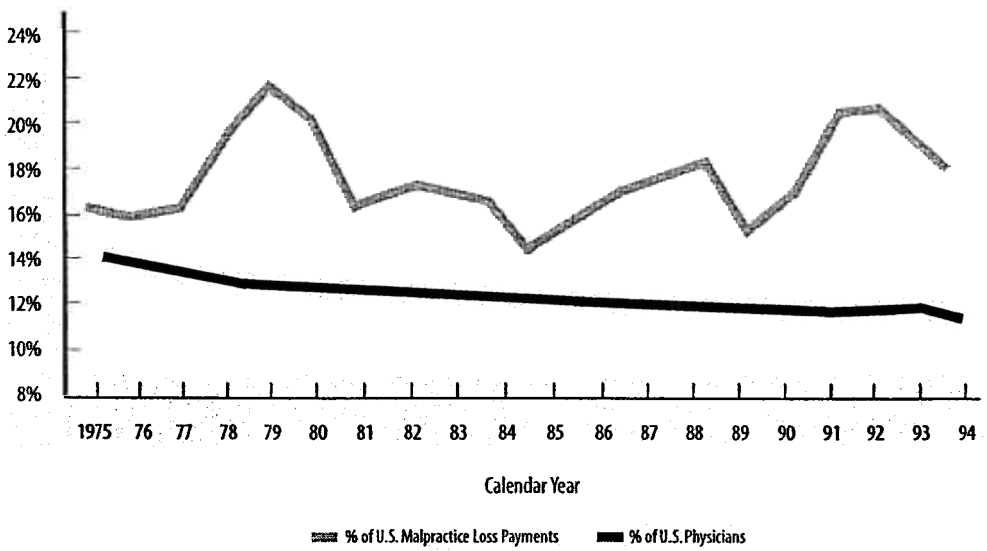
centage of loss payments has dropped dramatically since enactment of the MICRA package of tort reforms. Before MICRA's adoption in 1975, California's percentage of loss payments was significantly higher than its proportion of physicians. By 1981, California's loss payments had dropped and were about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

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

New York

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

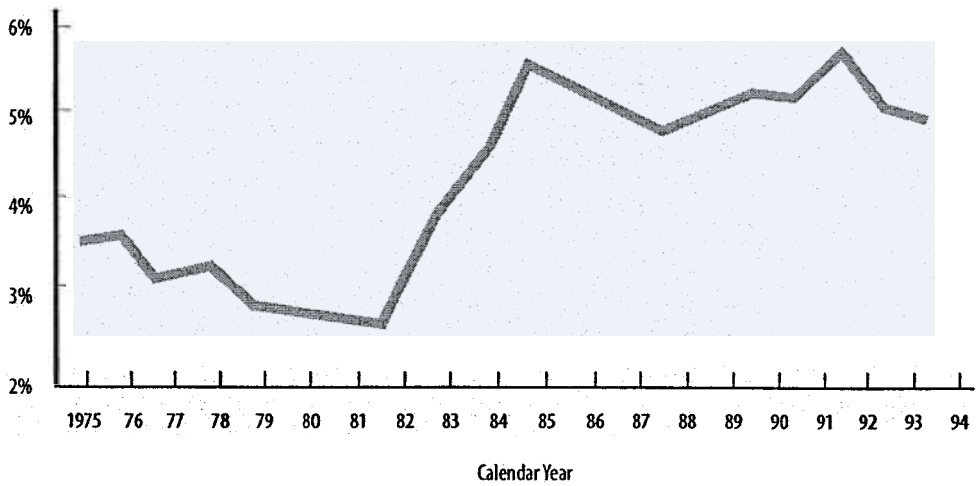
Exhibit 3
Malpractice Loss Payments in New York as a Percentage of the U.S. Total, 1975–94



Ohio

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

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



Conclusions

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

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

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

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

TABLE 5. Comparison of States with Caps to States without Meaningful Non-Economic Caps
(Average Premium Increase)

States with Caps ≤ $250,000		States without Caps	
California	20%	Arkansas	18%
Indiana	15%	Connecticut	50%
	21%	Georgia	32%
	5%	Nevada	35%
		New Jersey	24%
		Oregon	56%
		Pennsylvania	77%
		Washington	55%
		Ohio	60%
		West Virginia	30%
AVERAGE	**15%**	**AVERAGE**	**44%**
States with Caps ≤ $350,000		**States without Caps**	
California	20%	Arkansas	18%
Hawaii	0%	Connecticut	50%
	15%	Georgia	32%
	39%	Nevada	35%
Montana	21%	New Jersey	24%
	13%	Oregon	56%
	0%	Pennsylvania	77%
	0%	Washington	55%
	5%	Ohio	60%
	5%	West Virginia	30%
AVERAGE	**12%**	**AVERAGE**	**44%**

SOURCE: Medical Liability Monitor, 2001. Percentages represent the combined average of the highest premium increases for OB/GYNs, Internists, and General Surgeons among select states, 2000-2001. Average highest premium increase is derived from the highest potential premium increase among internal medicine, general surgery or obstetrics/gynecology specialists in that state during 2001. These combined averages are not weighted.

As Table 6 below shows, there is a substantial difference in the level of medical malpractice premiums in states with meaningful caps, such as California, Wisconsin, Montana, Utah and Hawaii, and states without meaningful caps.

TABLE 6. Malpractice Liability Rate Ranges by Specialty by Geography as of July 2001			
	Cap in Non-Economic Damages	Low	High
INTERNISTS			
Wisconsin	$350,000	$5,000	$6,000
Montana	$250,000	5,300	7,000
Utah	$250,000	5,900	5,900
Hawaii	$350,000	6,800	6,800
Connecticut	No cap	6,200	15,800
Washington	No cap	7,100	9,000
Metropolitan Area Data			
California (Los Angeles area)	$250,000	$7,900	$13,000
Pennsylvania (Urban Philadelphia area)	No cap		11,800
Nevada (Las Vegas area)	No cap	11,600	15,800
Illinois (Chicagoland area)	No cap	16,500	28,100
Florida (Miami and Ft. Lauderdale areas)*	No cap	17,600	50,700
GENERAL SURGEONS			
State Wide Data			
Wisconsin (state wide)	$350,000	$16,000	$17,500
Montana (state wide	$250,000	23,300	27,000
Utah (state wide)	$250,000	26,200	26,200
Hawaii (state wide)	$350,000	24,500	24,500
Connecticut (state wide)	No cap	26,200	45,800
Washington (state wide)	No cap	20,100	32,600
Metropolitan Area Data			
California (Los Angeles area)	$250,000	$23,700	$42,200
Pennsylvania (Urban Philadelphia area)	No cap	31,500	35,800
Nevada (Las Vegas area)	No cap	40,300	56,900
Illinois (Chicagoland area)	No cap	50,000	70,200
Florida (Miami and Ft. Lauderdale areas)*	No cap	63,200	126,600
OBSTETRICIANS/GYNECOLOGISTS			
State Wide Data			
Wisconsin (state wide)	$350,000	$23,800	$27,500
Montana (state wide	$250,000	36,000	38,600
Hawaii (state wide)	$350,000	40,900	40,900
Utah (state wide)	$250,000	44,300	44,300
Connecticut (state wide)	No cap	45,400	64,800
Washington (state wide)	No cap	34,100	59,300
Metropolitan Area Data			
California (Los Angeles area)	$250,000	$46,900	$57,700
Pennsylvania (Urban Philadelphia area)	No cap	45,900	66,300
Nevada (Las Vegas area)	No cap	71,100	94,800
Illinois (Chicagoland area)	No cap	72,500	110,100
Florida (Miami and Ft. Lauderdale areas)*	No cap	108,000	208,900

Source: Medical Liability Monitor, Vol. 26, No. 10, October 2001: Shook, Hardy, Bacon, L.L.P. October 9, 2001.

* Florida imposes caps of $250,000-350,000 unless neither party demands binding arbitration or the defendant refuses to arbitrate.

EXHIBIT B-2

OHIC Insurance Company
State Rate Comparison
Mature Claims Made Physician Rates
$1 Million / $3 Million Limits

Specialty	OH	IL		IN*		KS		KY	
	Rate (Terr 1)	Rate (Terr 3)	Relativity	Rate (Terr 1)	Relativity	Rate	Relativity	Rate	Relativity
Family Physicians or General Practitioners - No Surgery 80420	13,452	10,661	0.793	5,791	0.430	10,559	0.785	9,315	0.692
Pediatrics - No Surgery 80267	13,452	11,342	0.843	5,791	0.430	11,233	0.835	9,911	0.737
Family Physicians or General Practitioners - Minor Surgery 80421	18,770	17,011	0.906	9,386	0.500	16,850	0.898	14,866	0.792
Anesthesiology 80181-3 / 80151	22,523	22,682	1.007	10,038	0.446	22,466	0.997	19,820	0.880
Emergencey Medicine - No Major Surgery 80102	31,283	23,817	0.761	10,908	0.349	33,699	1.077	20,812	0.665
Surgery - Orthopedic 80154	45,361	44,230	0.975	25,809	0.569	67,399	1.486	38,650	0.852
Surgery - Obstetrics - Gynecology 80153	64,131	68,047	1.061	27,098	0.423	43,809	0.683	59,462	0.927

OH		IL		IN*		KS		KY	
Territory	Relativity	Territory	Relativity	Territory	Relativity	Territory	Relativity	Territory	Relativity
1	1.000	1	1.743	1	1.000				
2	1.400	1A	1.580	2	0.787				
3	1.250	2	1.413						
		3	1.000						

* In Indiana there are only $250,000 / $750,000 limits as it is a fund state. An ILF (of 1.5625) was used to bring the rate to the $1,000,000 / $3,000,000 level.

Specialty	OH	MD		NE		WI		WY	
	Rate (Terr 1)	Rate (Terr 1)	Relativity	Rate	Relativity	Rate	Relativity	Rate	Relativity
Family Physicians or General Practitioners - No Surgery 80420	13,452	6,246	0.464	7,417	0.551	5,629	0.418	8,965	0.666
Pediatrics - No Surgery 80267	13,452	6,644	0.494	7,892	0.587	5,629	0.418	9,538	0.709
Family Physicians or General Practitioners - Minor Surgery 80421	18,770	10,497	0.559	11,836	0.631	11,259	0.600	14,307	0.762
Anesthesiology 80181-3 / 80151	22,523	18,204	0.808	15,782	0.701	10,670	0.474	19,076	0.847
Emergencey Medicine - No Major Surgery 80102	31,283	16,078	0.514	23,674	0.757	12,665	0.405	28,613	0.915
Surgery - Orthopedic 80154	45,361	63,582	1.402	47,346	1.044	27,019	0.596	57,228	1.262
Surgery - Obstetrics - Gynecology 80153	64,131	28,303	0.441	30,774	0.480	32,086	0.500	37,198	0.580

OH		MD		NE		WI		WY	
Territory	Relativity	Territory	Relativity	Territory	Relativity	Territory	Relativity	Territory	Relativity
1	1.000	1	1.000						
2	1.400	2	1.228						
3	1.250	3	1.351						

State	Effective Date
Ohio	7/1/2003
Illinois	12/1/2002
Indiana	4/1/2003
Kansas	7/1/2002
Kentucky	4/1/2003
Maryland	4/15/2002
Nebraska	7/1/2002
Wisconsin	11/1/2002
Wyoming	1/15/2003

EXHIBIT B-3

OHIC Insurance Company
State Rate Comparison
Mature Claims Made Facility Rates
$200,000 / $600,000 Limits

Exposure Type	OH	IL		IN*		KS		KY	
	Rate (Terr 1)	Rate	Relativity	Rate	Relativity	Rate	Relativity	Rate	Relativity
Acute Bed	1,821	2,272	1.248	1,344	0.738	1,256	0.689	947	0.520
Bassinets	1,821	2,272	1.248	1,344	0.738	1,256	0.689	947	0.520
Long Term Care	546	682	1.248	403	0.738	377	0.689	284	0.520
Nursing Home	127	159	1.248	94	0.738	88	0.689	66	0.520
Psychiatric	911	1,136	1.248	672	0.738	628	0.689	474	0.520
Out Patient Visits (per 100)	55	68	1.248	40	0.738	38	0.690	28	0.520
			-		-		-		-

OH		IL		IN*		KS		KY	
Territory	Relativity	Territory	Relativity	Territory	Relativity	Territory	Relativity	Territory	Relativity
1	1.000								
2	1.150								

* In Indiana there are only $100,000 / $300,000 limits as it is a fund state. An ILF (of 1.2479) was used to bring the rate to the $200,000 / $600,000 level.

Exposure Type	OH	MD		NE*		WI		WY	
	Rate (Terr 1)	Rate (Terr 2)	Relativity	Rate	Relativity	Rate	Relativity	Rate	Relativity
Acute Bed	1,821	1,639	0.900	884	0.485	995	0.546	1,507	0.828
Bassinets	1,821	1,639	0.900	884	0.485	995	0.546	1,507	0.828
Long Term Care	546	492	0.900	265	0.485	299	0.546	452	0.828
Nursing Home	127	115	0.900	62	0.486	70	0.546	105	0.828
Psychiatric	911	819	0.900	442	0.485	498	0.546	754	0.828
Out Patient Visits (per 100)	55	49	0.900	27	0.494	30	0.546	45	0.828
			-		-		-		-

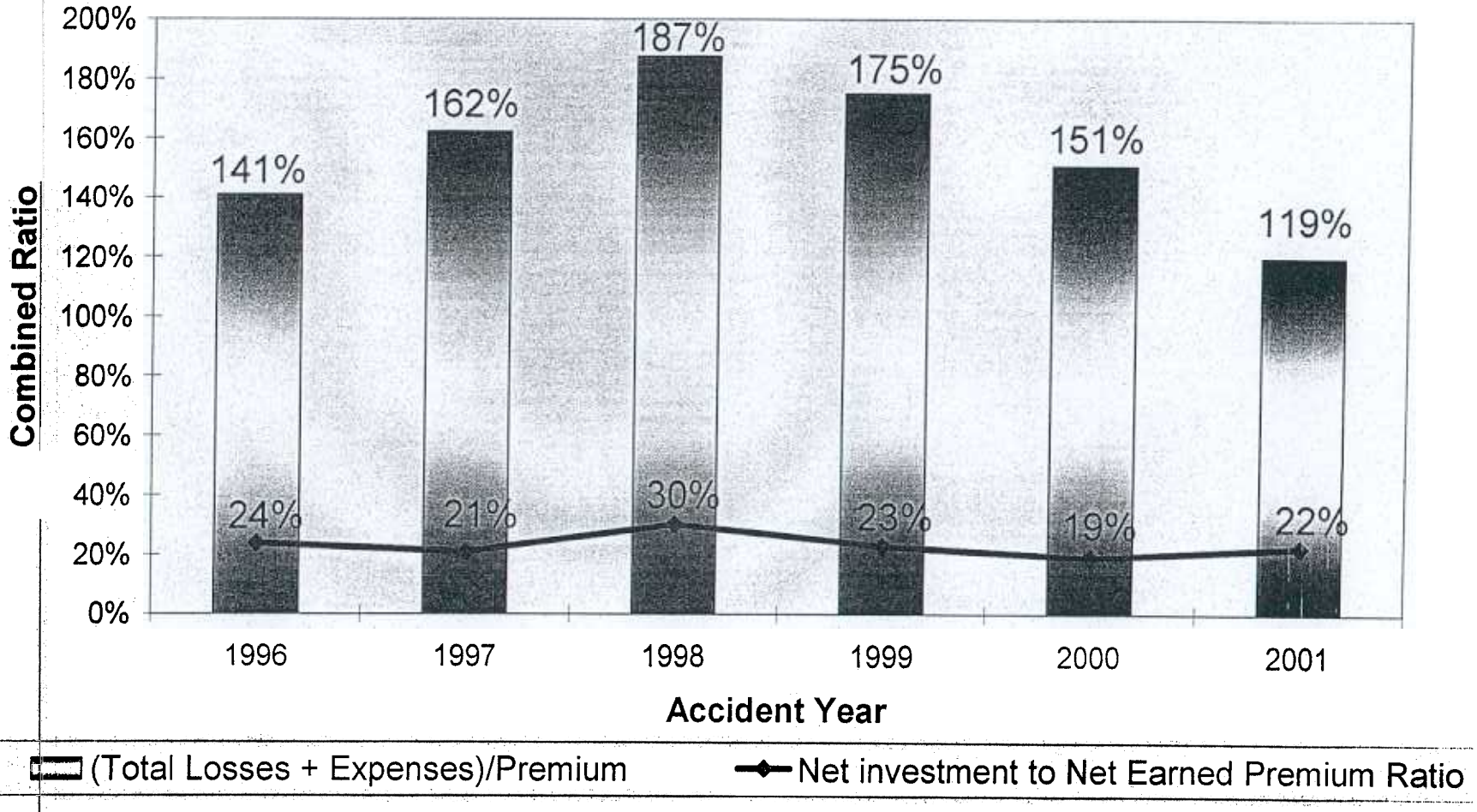
OH		MD		NE*		WI		WY	
Territory	Relativity	Territory	Relativity	Territory	Relativity	Territory	Relativity	Territory	Relativity
1	1.000	1	1.500						
2	1.150	2	1.000						

* The Nebraska rate shown is for facilities participating in the state's fund.

State	Effective Date
Ohio	12/1/2002
Illinois	3/1/2002
Indiana	4/1/2003
Kansas	7/1/2002
Kentucky	4/1/2003
Maryland	4/1/2002
Nebraska	11/25/2002
Wisconsin	12/1/2002
Wyoming	1/15/2003

EXHIBIT C

OHIC Insurance Company
Combined Ratios
Physician Medical Malpractice (AS Line 11)
Ohio
Data as of June 30, 2002



How a cap works

- W scons n caps non economic damages e pa n & suffering at $400 000
- Jury Verd ct award $12 7 mi on (May 02
- OHIC C a m Pa d

Future med ca care fe care	$4 7 mi on
Past medical expenses	1 0 mi on
Future oss of earn ngs	0 4 mi lion
Past loss of earn ngs	0 1 mi on
Out of pocket costs	0 1 mi ion
Pa n & S ffer n g $6.5M capped	0.4 million
TOTAL CLAIM PAID	$6 7 mi lion

EXHIBIT E

All claims except as noted (1987) have been reported since 1994

Settlements — Verdicts

OHIC Insurance Company Data as of 10/31/02 Report includes claims and lawsuits in which the total cost of the action is in excess of $250,000.					
Wyoming (F)acility or (P)hysician	Total Cost of Claim (Indemnity and Expense)	Direct (1) Indemnity Paid	Direct (2) Expense Paid	Direct (3) Indemnity Resrve	Direct (4) Expense Reserve
F	400,373	-	400,373	-	-
F	356,217	-	71,217	250,000	35,000
F	275,000	-			
F	425,000	-	-		
F	286,086	190,000	96,086	-	-
F	300,000	300,000	-	-	-
F	400,260	325,000	75,260	-	-
F	384,604	350,000	34,604	-	-
F	(1987) 620,396	500,000	120,396	-	-
F	567,112	500,000	67,112	-	-
F	698,467	550,000	148,467	-	-
F	611,789	601,892	9,897	-	-
F	1,597,351	1,500,000	97,351	-	-
F	2,024,839	1,874,935	149,904	-	-
P	313,000	-	181,836	50,000	
P	458,000	-	57,034		
P	560,000	-	-		
P	750,000	-		700,000	
P	271,901	250,000	21,901	-	-
P	300,000	300,000	-	-	-
P	378,440	349,859	28,581	-	-
P	354,820	350,000	4,820	-	-
P	483,142	400,000	83,142	-	-
P	529,742	424,310	105,432	-	-
P	649,679	600,000	49,679	-	-
P	632,000	600,000	19,760	-	12,240
P	908,711	750,000	158,711	-	-
Total	15,536,928	10,715,996	2,003,654	2,450,000	367,278

(1) Settlements or verdicts paid to claimants.

(2) Costs for defense attorneys, med experts, copying medical records, and other fees & costs. Does not include any administrative costs as those are dealt with in rate setting.

(3) Estimated settlement or verdict costs of unresolved claims.

Rate Increases

Physicians	(filed)	(approved)
1-15-03	+15%	+14.67%
11-1-01	+23.89%	+23.8%
1-1-98	-.7%	-.7%
1-1-95	-3.1%	-3.1%

Hosp.	(filed)	(approved)
12-1-02	+21%	+21%
11-1-01	+22%	+22%

no filings between 1995 – 2001