Wyoming Healthcare Commission

T. Chris Muirhead, Chairman

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MEDICAL MALPRACTICE INSURANCE

COMPARISONS OF RATES IN WYOMING & SURROUNDING STATES

Health care commission duties

W.S. 9-2-2803(a) The commission shall develop strategies to improve health care and reduce health care and medical liability insurance costs for Wyoming citizens by holding public meetings throughout the state, hearing from experts and other interested parties, studying and researching other states' actions on health care and medical liability insurance reform, studying and utilizing Wyoming data, considering past efforts, including, but not limited to, the report issued by the Wyoming health reform commission on December 1, 1994, and future possibilities that can be useful in decision making

Background:

By request of the Wyoming Healthcare Commission (WHC), the two physician liability insurers who write policies for over 80% of Wyoming physicians, The Doctor's Company and OHIC, were asked to provide base rate data which would allow WHC members to fairly and accurately view variations between physician liability insurance premiums for physicians in Wyoming and all adjacent states.

According to information supplied by Wyoming Insurance Commissioner, Kenneth G. Vines, the medical malpractice insurance market in Wyoming is considered a noncompetitive line since two companies supply over 80% of the market. According to the most recent NAIC Market Share Report (for 2001), OHIC accounted for 47.27% of the market while The Doctor's Company share was 36.15%. Together, these two companies comprised 83.42% of the total market. The next closest competitor in 2001 was the St. Paul Company (3.43%), which has since ceased writing medical malpractice policies.

For the purposes of this comparison, it is important to be able to compare Wyoming's rates for the same primary and specialty care areas with those of other states in our geographic region. Geographic considerations are important because it is logical to conclude that physicians who might choose to practice

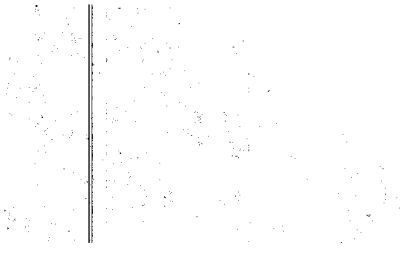
medicine in Wyoming would also be attracted to surrounding states with rural and intermountain West characteristics. The list of comparables is by no means exhaustive, but includes common primary care designations such as family general practice with and without OB, general surgery, and emergency medicine; as well as several common specialty areas that are more likely to be available on a regional basis such as orthopedic surgery, cardiology and neurosurgery. All numbers are reported for $1 million/$3 million limits on claims.

Base rates were requested for the following states:

- Wyoming
- Colorado
- Idaho
- Montana
- Nebraska
- North Dakota
- South Dakota
- Utah

Base rates were requested for the following categories of physician practice:

- Family Practice with OB
- Family Practice without OB
- General Surgery
- Emergency medicine
- OB/GYN
- Gynecology – major surgery
- Orthopedic Surgery
- Cardiology
- Neurosurgery



OHIC:

OHIC's Melissa S. Denison, Director of Business Development, indicated that she was unable to provide the specific information requested for several reasons:

1) OHIC does not write policies in any states surrounding Wyoming. At one time, OHIC did conduct business in Montana, but they chose to withdraw from the medical malpractice market in that state when insurance regulations became too onerous.
2) OHIC does not capture all the requested practice areas
3) OHIC classifies family practitioners who do over 30 deliveries per year as OB/GYNs for insurance purposes

OHIC did send one chart (*see Attachment A*), which included some comparisons

of states they do cover: Ohio, Illinois, Indiana, Kansas, Kentucky, Maryland, Wisconsin, and Wyoming; and for the following categories: Family practice – no surgery; pediatrics – no surgery; family practice – minor surgery; anesthesiology; emergency medicine – no major surgery; orthopedic surgery; and OB/GYN surgery.

Since OHIC was not able to supply the exact data requested (base rates for Wyoming and 7 surrounding states; 9 specific practice areas), no in-depth analysis of the numbers reported by them has been done. Generally, however, it is interesting to note two things with respect to OHIC's chart:

1. Of the 8 states included, four (OH, IL, KY and WY) are designated "Crisis States" on the AMA's Liability Map (*see Attachment B*). In general, these states had higher base rates than the two states (IN, WI) listed as "currently okay".
2. According to Ken Bruce, OHIC Sr. Underwriter, Kansas and Indiana both have an insurance stabilization fund system in place where the private carrier (OHIC) provides the primary layer and the state provides an additional layer of coverage. In Kansas, OHIC sells $200,000/$600,000 and the hospital or physician purchases one of three different additional limits from the state to bring total individual coverage to $100,000/$300,000; $200,000/$600,000; or $800,000/$2,400,000. The doctor chooses the additional layer and a surcharge is paid according to the state's formula. In Indiana, OHIC sells $250,000/$750,000 to the physician and the state provides an additional $1 million of coverage. Clearly, the Indiana system seems to be more effective in stabilizing premiums than the one being used in Kansas based solely on base rates comparisons.

<u>The Doctor's Company:</u>

For this analysis, it is important to note that The Doctor's Company (TDC) is a physician-owned mutual company that returns any profits to policy-holders. Because of this, we have made the assumption that profit-making is not a primary driver in the setting of rates.

It is also important to note that the numbers quoted (in dollars) are for base rates and not for total premiums. In many cases, since rates fluctuate due to other variables such as years in practice and claims experience, we are finding that actual premiums are often much higher than these numbers. Because of these other factors, however, base rates are the only true comparables from state to state and across practice categories.

Michael O'Donohue, Sr. Vice-President with The Doctor's Company (TDC), was able to provide all information requested (*see Attachment C*). The numbers leave

little doubt that Wyoming physicians, overall, are indeed paying more for standard$1 million/$3 million coverage than their counterparts in surrounding states:

- **Of the 11 practice categories listed, Wyoming's rates were the highest among the eight regional states in all but 2 instances. In those 2 cases where Wyoming's rate was not the highest, Emergency Medicine and General Surgery, it was the third-highest, but still very close to the rates of those states that were second-highest.**
  In both cases where Wyoming's rates were not the highest, Utah's were. However it is important to note that Utah passed some reforms in March, 2003, which have not yet had time to affect medical liability rates. Montana's unfriendly insurance company climate has already been noted; and the rates listed for Colorado must be compared with COPIC rates (*attachment G*) for the same practice areas—specifically for General Surgery $44,320—TDC; $32,916—COPIC. Since COPIC covers about 80% of physicians who buy insurance in Colorado, according to COPIC Executive Vice President, George Dikeou, it is likely that the base rates quoted by TDC for Colorado reflect the probability that higher-risk physicians might be paying steeper rates to TDC after COPIC declines coverage.
  South Dakota, Nebraska, and Idaho had the lowest overall rates. When identifying potential factors causing the medical malpractice base rates to be consistently lower in those 3 states, similarities in each state's liability reform laws were considered (*see attachments D and E*). Notable items include:
  - **South Dakota has a $500,000 cap on total damages; Nebraska caps total damages to $1.75 million, but caps individual healthcare providers' liability at $200,000 with any additional damages being paid from an excess coverage fund; Idaho has a $250,000 cap on noneconomic damages and a $1 million cap on total damages, while Wyoming has no limits.**
  - **South Dakota, Nebraska, and Idaho all have Collateral Source Reforms, while Wyoming has none.**
  - **South Dakota and Idaho allow for periodic payment of damages, while Nebraska and Wyoming do not.**
  - **Nebraska and Idaho require pre-trial arbitration/screening panels. South Dakota has an arbitration panel that determines the existence of liability and allows time for parties to agree on damages. If parties cannot agree, the panel makes a determination. Wyoming permits—but does not require—arbitration.**
  - **South Dakota, Nebraska and Idaho all require expert testimony to establish negligence. Wyoming does not.**

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ATTACHMENTS

A

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

Specialty	OH	IL	IN	KS	KY	MD	WI	WY
	Rate (Terr 1)	Rate (Terr 3)	Rate (Terr 1)	Rate	Rate	Rate (Terr 1)	Rate	Rate
Family Physicians or General Practitioners - No Surgery 80420	13,452	10,661	5,791	10,559	9,315	6,246	5,629	8,965
Pediatrics - No Surgery 80267	13,452	11,342	5,791	11,233	9,911	6,644	5,629	9,538
Family Physicians or General Practitioners - Minor Surgery 80421	18,770	17,011	9,386	16,850	14,866	10,497	11,259	14,307
Anesthesiology 80181-3 / 80151	22,523	22,682	10,038	22,466	19,820	18,204	10,670	19,076
Emergencey Medicine - No Major Surgery 80102	31,283	23,817	10,908	33,699	20,812	16,078	12,665	28,613
Surgery - Orthopedic 80154	45,361	44,230	25,809	67,399	38,650	63,582	27,019	57,228
Surgery - Obstetrics - Gynecology 80153	64,131	68,047	27,098	43,809	59,462	28,303	32,086	37,198

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

Wyoming Medical Society

Physician Newsletter

June/July 2003

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2 Update on Liability Reform

3 Annual Meeting Wrap-up

4 WMS Celebrates 100 Years!

5 Liability Problem Areas in WY

Special Insert: Sign up to be a WMS Action Team Volunteer

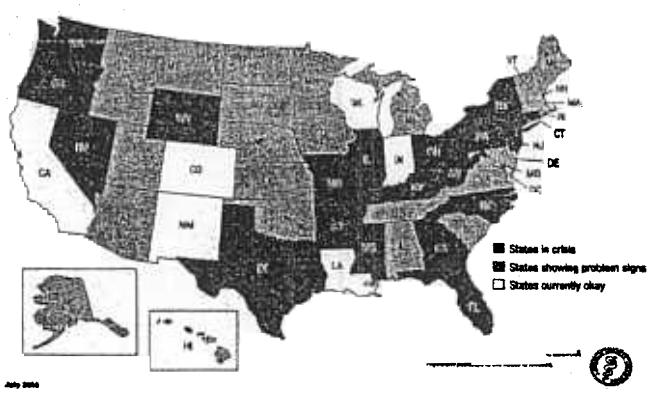
Brochure Enclosed: Wyoming EMSA Seminar for Office Managers

Wyoming is Now a "Crisis State" on AMA Liability Map

On July 8, the American Medical Association declared Wyoming a medical liability insurance crisis state as more and more Wyoming doctors relocate, retire or restrict the services they provide to patients.

The AMA was "disheartened" to announce that Wyoming had been designated a crisis state because of increasing threats of further reductions in patients' access to health care and noted that the state's lack of liability reforms was a leading factor in surgeons and obstetricians leaving the state or no longer delivering babies.

America's Medical Liability Crisis: A National View



"When pregnant moms in towns like Newcastle face a 30-90 mile drive to have their babies delivered, we can no longer avoid a 'crisis' designation," Robert Monger, MD, Vice President of the Wyoming Medical Society, said.

According to AMA President Donald J. Palmisano, MD, "Wyoming patients are being hit particularly hard by the current crisis -- where even the loss of one physician can cripple a rural community." Wyoming is the 19th state declared to be in crisis by the AMA, but is the only one in the Mountain West, making it easier for doctors to relocate to neighboring states and making it much harder to recruit new doctors.

"Wyoming is already losing doctors and medical services," said Robert Stuart, MD, Vice President of Medical Affairs at United Medical Center in Cheyenne. "Under a crisis state designation, it will become even harder for hospitals to recruit the right mix of physicians to assure that we can continue to provide the necessary medical care for our communities."

The WMS list of "problem areas" where patients are in danger of losing care extends throughout the state. The most recent example highlights three family physicians in Newcastle who can no longer deliver babies due to unaffordable liability rates.

WMS President Stephen Brown, MD noted earlier that the Newcastle situation was not an isolated case. "More and more of our patients will be impacted as Wyoming's doctors are forced to consider the three R's of the medical liability crisis: restrict, relocate or retire. Physicians must make the difficult choice to restrict patient services, relocate to another state, or retire completely from practice," he said.

~ see Crisis State continued on page 8

(b)

Wyoming Medical Society
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~ Crisis State continued from page 1

The solution to the crisis, Dr. Monger said, is meaningful tort reform modeled on reforms enacted in California's MICRA legislation, including caps on non-economic damages. "The evidence is clear that those reforms have helped hold down costs and have protected patient access to care," Dr. Monger noted. "To make that happen will require an amendment to the Wyoming Constitution or passage of legislation in Congress."

U.S. Senator Mike Enzi has been actively participating in the medical liability debate being waged in the U.S. Senate. "This problem is not just about lawsuits and insurance rates. It's about people who can't get the medical attention they need. It's about communities without doctors to serve them. It's about a healthcare system in crisis," said Enzi. "The shortcomings of our medical litigation system make it clear that it is time for a major change. The legislation we must consider is an important step toward making the medical justice system work better for everyone, not just a fortunate handful of personal injury lawyers."

U.S. Senator Craig Thomas is also concerned about the effects of increasing liability insurance premiums on patient access, especially for seniors. "Rising liability premiums combined with low Medicare payments have caused many physicians to limit the number of Medicare patients they treat, creating access problems for Wyoming's seniors," he said. Medical liability legislation being considered in the U.S. Senate "will help us attract more doctors and keep the ones we've got," he added.

"This crisis designation points out the very real and very serious problem facing Wyoming," Dr. Stuart said. "Nobody wants to be named a 'crisis state' when we're talking about something as valuable as medical care for Wyoming families."

Dr. Monger asked patients, physicians and other concerned citizens to consider how serious Wyoming's problem is, and urge both the U.S. Congress and the Wyoming Legislature to take action soon. "Ask yourself, 'Will my doctor be there when I need medical care?'" ■

THE DOCTORS COMPANY, AN INTERINSURANCE EXCHANGE
$1M/$3M Limit Mature Claims-Made Coverage

SPECIALTY	State							
	WY	CO	ID	MT	ND	NE	SD	UT
PHYSICIANS/SURGEONS								
Cardiology (Invasive)	27,789	16,504	13,297	20,015	15,829	12,510	9,292	19,363
Emergency Medicine	25,733	24,744	20,032	26,216	22,602	18,642	13,693	28,535
Family General Practice (No Surgery-Hospital Care)	12,593	8,918	6,747	9,550	7,872	6,542	4,715	9,824
Family General Practice(Minor Surgery-No Obstetrics)	16,583	12,716	9,513	13,619	11,085	9,232	6,403	13,860
Family General Practice (Restricted Major Surgery-No Obstetrics)	26,237	16,971	13,832	20,015	15,133	12,576	9,129	19,024
Family General Practice (With Obstetrics)	38,945	23,539	19,287	28,977	21,979	17,740	12,745	27,232
General Surgery	44,320	44,927	37,203	38,697	38,959	33,438	23,226	50,227
Gynecology (Major Surgery)	32,977	22,660	18,530	25,947	20,103	16,697	12,063	25,139
Neurosurgery	89,927	74,494	62,100	74,304	59,856	52,200	34,934	75,619
Obstetrics & Gynecology	68,608	51,074	40,416	57,166	47,341	39,209	28,951	60,332
Orthopedic Surgery	51,438	34,529	26,440	38,178	31,056	25,567	17,796	38,523

D

State Liability Reform Laws: Wyoming & Surrounding States

Source: American Medical Association Advocacy Research Center

State	Damage Caps	Collateral Source Reform	Periodic Payments Permitted	Joint Liability Reform	Attorney Fees Limited
Colorado	$300,000 cap on noneconomic damages, including damages for physical impairment and disfigurement $1,000,000 cap on total damages. Separate $250,000 limit on derivative noneconomic damages (nonpecuniary harm to person other than person suffering from direct injury or loss). (1988)	Yes, benefits from collateral sources must be disclosed and used to reduce recoverable economic damages, minus any amount paid by the claimant to secure the benefit.	Yes. Mandatory for awards of future damages greater than $150,000. Discretionary for damage awards $150,000 or less.	Yes. Defendants are responsible only for their proportionate share of negligence unless persons have consciously conspired and deliberately pursued a common plan or design to commit a tortious act.	No
Idaho	$250,000 cap on noneconomic damages per claimant in all personal injury and wrongful death actions. Cap will be adjusted annually beginning on July 1, 2004 based on the average state wage increase. Cap does not apply to willful or reckless conduct or felonious acts. (2003)	Yes, collateral sources may be submitted to the judge following the verdict Judgments may be entered only for amounts that exceed recovery from collateral sources.	Yes, upon the request of either party, at the discretion of the court, and only in PI cases, where damages exceed $100,000. May not be ordered for intentional torts, gross negligence or an extreme deviation from reasonable standard of conduct.	Yes. Defendants are responsible only for their proportionate share of negligence, except where co-defendants were acting in concert or a person is an agent or servant of a party.	No
Montana	$250,000 cap on noneconomic damages (1995, 1997)	Yes, in cases where damages exceed $50,000. Total damages must be reduced by amount of prior payment from collateral sources that do not involve rights of subrogation.	Yes. Upon any party's request, the court must enter an order for periodic payment of future damages exceeding $50,000.	Any party whose negligence is 50% or less of the combined negligence of all persons is severally liable only. The remaining parties are jointly and severally liable for the total less the amount attributable to the claimant. A party may be jointly liable for all damages caused by the negligence of another if both acted in concert or if one party acted as an agent of the other.	No

State Liability Reform Laws: Wyoming & Surrounding States

Source: American Medical Association Advocacy Research Center

State	Damage Caps	Collateral Source Reform	Periodic Payments Permitted	Joint Liability Reform	Attorney Fees Limited
Nebraska	$1.75 million in total damages. 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) shall not be liable for more than $200,000 in total damages. Any excess damages shall be paid from the excess coverage fund. (1975, 1984, 1986, 1992)	Yes. The court shall determine in a separate hearing the amount of any credit against a claimant's damages based on any non-refundable insurance benefits reimbursed to the claimant. This information, however, is not admissible as evidence.	No	Yes. Defendants are responsible only for their proportionate share of negligence, except where parties have acted in concert and caused harm as part of a common enterprise or plan.	No, but upon motion of either party, the court must review and determine reasonableness of fees.
South Dakota	$500,000 cap on total general damages (1985)	Yes, but no evidence of payments subject to subrogation and not purchased by the claimant or paid by the government.	Yes. If a party makes an effective election and both parties agree or a timely objection is not filed, or if a timely objection is filed but the claimant can prove future damages are in excess of $200,000.	No. Each party is jointly and severally liable, but parties who are allocated less than 50% of the total fault may only be jointly liable for more than 2xs the percentage of fault allocated to that party.	No
Utah	$250,000 cap on noneconomic damages, indexed for inflation. For causes of action arising on or after 7/1/2001 but before 7/1/02 limit increased to $400,000. Limit adjusted annually for inflation thereafter. (1986, 2001)	Yes. Court must reduce damages by any collateral sources of payment received by the claimant, except for benefits from payors with subrogation rights. Reduction shall be offset by amount paid by claimant to secure such benefits.	Yes. Any party may request periodic payments, and the court must order such payments if future damages exceed $100,000.	Yes. Defendants are responsible only for their proportionate share of negligence.	Yes. Total compensation may not exceed 1/3 of total damages.
Wyoming	None - Constitution prohibits caps	No	Not mandated	Yes. Defendants are responsible only for their proportionate share of negligence.	No

State Liability Reform Laws: Wyoming & Surrounding States

Source: American Medical Association Advocacy Research Center

	Arbitration/Mediation and Pre-Trial Screening Panels	Expert Testimony & Qualifications	Affidavit/ Certificate of Merit	Statute of Limitations
	Arbitration is not mandated but is permitted. (CRS §13-64-403 (2002))	Experts must be licensed to practice in the state and be substantially familiar with the applicable standards of care and practice as they relate to the act or omission which is the subject of the claim on the date of the incident. The court shall not permit an expert in one medical subspecialty to testify against a physician in another medical subspecialty unless the expert shows substantial familiarity between the specialties and that the standards of care and practice in the two fields are similar. The limitations in this section shall not apply to expert witnesses testifying as to the degree or permanency of medical or physical impairment. (C.R.S. § 13-64-401)	A certificate of review must be filed by the plaintiff or his attorney within 60 days after a complaint is served. The certificate must state that an expert was consulted, and the expert is competent to express a medical opinion on the case at issue. Failure to file a certificate will result in dismissal of the claim. (C.R.S. § 13-20-602)	Medical malpractice: within two years of the date when the alleged negligent act took place, and when its cause is known or should have been known. In no case may a claim be brought more than three years after the cause that gave rise to the action is known, unless the act or omission: was knowingly concealed; involved leaving a foreign object in the body; or both the act and injury otherwise could not have been discovered through the reasonable exercise of due diligence. Minors: minors under the age of 6 on the date of the alleged act or omission, must file an action before his or her eighth birthday Mentally incompetent or legally disabled: within two years of the discharge of disability status or within the applicable statute of limitations, whichever is later. Wrongful death: within two years of the date of death (CRS §§ 13-80-102.5, 13-8-103)
Idaho	Arbitration is permitted but not required. (7-901) Informal and nonbinding pre-trial screening panels are mandatory. Hearing Panels are appointed by the Board of Medicine and shall include a physician, attorney, and layperson agreed to by the panelists. In cases involving hospitals a hospital administrator shall also be appointed to the panel. (Idaho Code §§ 6.1001 through 6.1011)	To establish medical malpractice, the plaintiff must affirmatively prove by direct expert testimony and by a preponderance of all the competent evidence, that such defendant negligently failed to meet the applicable standard of care. The expert must possess professional knowledge and expertise coupled with actual knowledge of the applicable community standard to which his or her expert opinion testimony addresses. (Idaho Code §§ 6-1012, 6-1013)	No	Medical malpractice: within two years from the time of the occurrence of the wrongful act or omission at issue Foreign objects: within two years of when the claimant became aware of the injury, or one year following the date of the accrual, whichever is later Wrongful death: within two years of the date of death (Idaho Code § 5-219)

State Liability Reform Laws: Wyoming & Surrounding States

Source: American Medical Association Advocacy Research Center

State	Arbitration/Mediation and Pre-Trial Screening Panels	Expert Testimony & Qualifications	Affidavit/ Certificate of Merit	Statute of Limitations
Montana	Claimants must submit all malpractice claims or potential malpractice claims filed against health care providers to the panel prior to filing a complaint. Six members shall sit on the panel, including three attorneys and three providers from the same profession as the defendant (i.e. if the defendant is a physician, three physicians). The panel must decide whether there is substantial evidence that the acts complained of occurred, that they constitute malpractice, and whether there is a reasonable probability that the patient was injured thereby. The panel's decision must be in writing, but is not binding on any party. The panel's decision is not admissible in court, and no member of the panel may be called to testify at a subsequent trial. The panel may recommend an award, as well as discuss and approve settlement agreements. (Mont. Code Ann. § 27-6-101, et al.)	Expert testimony is generally required to establish a cause of action for medical malpractice. (Mont. Code Ch. 10 Rule 702)	No	Actions for injury or death based on alleged professional negligence shall be filed within three years of the date of the alleged negligence or the date when the negligence should have reasonably been discovered. No claims may be brought more than five years after the alleged negligence occurred. Minors under four: statute is tolled until the eighth birthday, or death, whichever is earlier, or during any period the child does not reside with a parent or guardian. (Mont. Code Ann. § 27-2-20
Nebraska	A medical review panel shall provide their expert opinion as to whether the defendant failed to meet the standard of care, or if there is a material issue of fact, not requiring expert opinion, bearing on liability for consideration by the court or jury. The panel shall consist of three physicians and one non-voting attorney who shall chair the panel. Each party to the action shall select one physician and these physicians shall agree on a third physician to sit on the panel. A fourth member shall be added in cases involving hospitals. The decision by a majority of the members of the panel shall be submitted to the court in writing. Either party may request a copy of the minority report if one exists. The majority and minority report may be submitted as evidence and any member of the panel may be called as a witness. (RRS Neb. §§ 44-2840 through 44-2847)	Expert testimony is required to establish a prima facie case of negligence in common law.	No	Medical malpractice: within two years after the act/omission giving rise to the action, or within one year after the claimant discovered/should have discovered the act/omission. Ten year statute of repose. (RRS Neb. § 44-2828) Under age 21: statute is tolled until claimant reaches age 21. (RRS Neb. § 25-213) Mental disorder: Statute is tolled until the disorder is removed. (RRS Neb. § 25-213)
South Dakota	Not mandated, but permitted. Arbitration panel determines existence of liability, then gives the parties 30 days to agree on damages. If the parties fail to agree, the panel will make a determination. (SD Codified Laws § 21-25B-1 et al.)	Expert testimony must be introduced to establish negligence.	No	Medical malpractice: within two years from the date of the alleged malpractice. Minor – within three years after the alleged malpractice, error, mistake, or failure to cure occurred, unless the minor is less than six years of age at the time the alleged malpractice occurred then within two years after the minor's sixth birthday. (SD Codified laws §§ 15-2-14.1 and 15-2-22.1 and 15-2-22)

State Liability Reform Laws: Wyoming & Surrounding States

Source: American Medical Association Advocacy Research Center

State	Arbitration/Mediation and Pre-Trial Screening Panels	Expert Testimony & Qualifications	Affidavit/ Certificate of Merit	Statute of Limitations
Utah	Arbitration agreements between a patient and health care provider are valid and enforceable. (78-14-17) Claimants may request a pre-litigation hearing. The panel conducting the hearing shall include a lawyer, health care provider who is practicing and knowledgeable in the same specialty as the proposed defendant, a lay person, and if the claim is against only a hospital or their employees a hospital administrator. The panel shall issue a written opinion whether the claim(s) against the defendant(s) has merit or no merit, and if a claim is determined to have merit, whether the conduct resulted in harm to the claimant. The panel's decision shall not be subject to judicial review or appeal and their decision shall not be admissible as evidence in any subsequent action. Members of the panel may also not be called to testify. The panel's decision may be binding if agreed to in writing by the parties. (78-14-12 through 78-14-16)	Expert testimony must be presented to establish a deviation below the standard of care, unless the facts are knowledgeable to a lay person.	No	Medical malpractice: within two years of the date the injury was/should have been discovered, but in no event more than four years after the negligent act. Wrongful death: same Foreign object: within one year from the date the object was/should have been discovered (four year limit does not apply) Minors/disabled: Same (NOTE: limits ruled unconstitutional for minors) (Utah Code Ann. § 78-14-4)
Wyoming	Arbitration permitted but not required. (Wyo. Stat. 1-36-101)	None	No	Medical malpractice claims must be brought within two years from the alleged act, error, or omission. If the claimant can prove the alleged act, error, or omission was not discoverable within a two year period, or failed to discover it within the two years despite due diligence then the cause of action must be brought within two years from the date of discovery. (if act discovered during the 2nd year of the two year period from the date of the act, the statute of limitations shall be extended six months) Minor: must be brought before minor's eighth birthday or as above, whichever is greater. Disabled: within one year from the removal of the disability. (Wyo. Stat. 1-3-107)

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United States General Accounting Office

GAO

Testimony

Before the Subcommittee on Wellness and Human Rights, Committee on Government Reform, House of Representatives

For Release on Delivery
Expected at 2:00 p.m. EDT
Wednesday, October 1, 2003

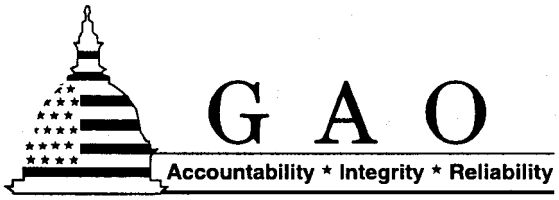
MEDICAL MALPRACTICE INSURANCE

Multiple Factors Have Contributed to Premium Rate Increases

Statement of

Richard J. Hillman, Director
Financial Markets and Community Investment

Kathryn G. Allen, Director
Health Care - Medicaid and Private Health Insurance Issues



GAO-04-128T

Mr. Chairman and Members of the Subcommittee:

We are pleased to be here today to discuss our work examining recent increases in premium rates for medical malpractice insurance and the effect of certain tort reform laws on premium growth. Since the late 1990s, medical malpractice insurance rates have increased dramatically for physicians in certain specialties in some states. These increases have heightened concerns that some health care providers may no longer be able to afford malpractice insurance, resulting in shuttered practices and reducing access to high-risk services. In response, some states have recently revised or have considered revising their tort laws, sometimes placing caps on damages in malpractice lawsuits, and the Congress is considering similar legislation.[1]

Our testimony today will focus on the factors that have contributed to the recent increases in insurance premium rates and the differences in rates among states that have passed varying levels of tort reform laws. Our findings are based on two reports we recently issued addressing various aspects of the recent increases in medical malpractice insurance rates.[2] Recognizing that the medical malpractice market varies considerably across states, as part of these reviews we judgmentally selected a number of states and conducted more in-depth reviews in each of those states.[3] Both our analyses and our conclusions are based in part on data and information we received from the states we visited and in part on analyses of national data from various sources.

In summary, multiple factors have contributed to the recent increases in medical malpractice premium rates in the states we analyzed. First, since 1998, insurers' losses on medical malpractice claims have increased rapidly in some states. We found that the increased losses appeared to be the greatest contributor to increased premium rates, but a lack of

[1]For example, on March 13, 2003, the House of Representatives passed the Help Efficient, Accessible, Low-cost, Timely Healthcare (HEALTH) Act of 2003 (H.R. 5); on June 27, 2003, a similar version (S.11) of this bill was introduced in the Senate.

[2]U.S. General Accounting Office, *Medical Malpractice Insurance: Multiple Factors Have Contributed to Increased Premium Rates*, GAO-03-702 (Washington, D.C.: June 27, 2003); and *Medical Malpractice: Implications of Rising Premiums on Access to Health* Care, GAO-03-836, (Washington, D.C.: Aug. 8, 2003).

[3]The states we visited were, for GAO-03-702, California, Florida, Minnesota, Mississippi, Nevada, Pennsylvania, and Texas; and for GAO-03-836, California, Colorado, Florida, Minnesota, Mississippi, Montana, Nevada, Pennsylvania, and West Virginia.

comprehensive data at the national and state levels on insurers' medical malpractice claims and the associated losses prevented us from fully analyzing the composition and causes of those losses. For example, data that would have allowed us to analyze claim severity at the insurer level on a state-by-state basis or to determine how losses were broken down between economic and noneconomic damages were unavailable. Second, from 1998 through 2001, medical malpractice insurers experienced decreases in their investment income[4] as interest rates fell on the bonds that generally make up around 80 percent of these insurers' investment portfolios. While almost no medical malpractice insurers experienced net losses on their investment portfolios over this period, a decrease in investment income meant that income from insurance premiums had to cover a larger share of costs. Third, during the 1990s, insurers competed vigorously for medical malpractice business, and several factors, including high investment returns, permitted them to offer prices that, in hindsight, did not completely cover the ultimate losses some insurers experienced on that business. As a result, some companies became insolvent or voluntarily left the market, reducing the downward competitive pressure on premium rates that had existed through the 1990s. Fourth, beginning in 2001, reinsurance rates for medical malpractice insurers also increased more rapidly than they had in the past, raising insurers' overall costs.[5] In combination, all of these factors have contributed to the movement of the medical malpractice insurance market through hard and soft phases—similar to the cycles experienced by the property-casualty insurance market as a whole—and premium rates have fluctuated with each phase.[6] Cycles in the medical malpractice market tend to be more extreme than in other insurance markets because of the longer period of time required to resolve medical malpractice claims, and factors such as changes in investment income and reduced competition can exacerbate the fluctuations.

[4]In general, state insurance regulators require insurers to reduce their requested premium rates in line with expected investment income. That is, the higher the expected income from investments, the more premium rates must be lowered.

[5]Reinsurance is insurance for insurance companies. They routinely use reinsurance as a way to spread the risk associated with the insurance they sell.

[6]Some industry officials have characterized hard markets as periods of rapidly rising premium rates, tightened underwriting standards, narrowed coverage, and the withdrawal of insurers from certain markets. Soft markets are characterized by relatively flat or slow rising premium rates, less stringent underwriting standards, expanded coverage, and strong competition among insurers.

In an attempt to constrain increases in medical malpractice premium rates, states have adopted various tort reform measures.[7] Of particular focus recently have been tort reform measures that include placing caps on monetary awards for noneconomic damages—such as pain and suffering—that may be paid to plaintiffs in a malpractice lawsuit. Available data, while somewhat limited in scope, indicate that rates of premium growth have been slower on average in states that have enacted tort reforms with noneconomic damage caps than in states with more limited reforms. Premium rates reported for three specialties—general surgery, internal medicine, and obstetrics and gynecology—were relatively stable on average in most states from 1996 through the late 1990s and then began to rise, but more slowly, in states with certain noneconomic damage caps. For example, from 2001 through 2002 average premium rates rose approximately 10 percent in the four states with noneconomic damage caps of $250,000 but approximately 29 percent in states with more limited tort reforms. As we have discussed, premium rate increases are influenced by multiple factors, and our analyses did not allow us to determine the extent to which the differences premium rate increases at the state level could be attributed to tort reform laws or to other factors.

Overall, adequate data do not exist that would allow us and others to provide definitive answers to important questions about the market for medical malpractice insurance, including an explanation of the causes of rising losses over time and the precise effect of tort reforms on premium rates. This lack of data is due, in part, to the nature of regulatory reporting requirements for all lines of insurance, which focus primarily on the information needed to evaluate a company's solvency. However, comprehensive data on individual awards actually paid in malpractice cases are also lacking, as are data on conditions in the health care sector that might affect the incidence and severity of medical malpractice suits.

Background

Nearly all health care providers buy medical malpractice insurance to protect themselves from potential claims that could otherwise cause financial distress or even bankruptcy. Under a malpractice insurance

[7]Medical malpractice lawsuits are generally based on principles of tort law. A tort is a wrongful act or omission by an individual that causes harm to another individual. To reduce malpractice claims payments and insurance premiums and for other reasons, some have advocated changes to tort laws, such as placing caps on the amount of damages or limits on the amount of attorney fees that may be paid under a malpractice lawsuit. These changes are collectively referred to as "tort reforms."

contract, the insurer agrees to investigate claims, to provide legal representation for the health care provider, and to accept financial responsibility for payment of any claims up to a specified monetary level during an established time period. The insurer provides this coverage in return for a fee—the medical malpractice premium. The most common physician policies provide coverage limits of $1 million per incident and $3 million per year.

Since 1999, medical malpractice premium rates for physicians in some states have increased dramatically. Among the states that we analyzed, however, we found that both the extent of the increases and the premium levels varied greatly not only from state to state but across medical specialties and even among areas within states. For example, the largest writer of medical malpractice insurance in Florida increased premium rates for general surgeons in Dade County by approximately 75 percent from 1999 to 2002, while the largest insurer in Minnesota increased premium rates for the same specialty by about 2 percent over the same period. The resulting 2002 premium rate quoted by the insurer in Florida was $174,300 a year, more than 17 times the $10,140 premium rate quoted by the insurer in Minnesota. In addition, the Florida insurer quoted a rate of $89,000 a year for the same coverage for general surgeons outside Dade County, or about half the rate it quoted inside Dade County.

In order to improve the affordability and availability of malpractice insurance and to reduce pressure on providers who could be faced with heavy liabilities, all states have adopted varying types of tort reform legislation. Tort reforms are generally intended to limit the number of malpractice claims or the size of payments in an effort to reduce malpractice costs and insurance premiums. Among the various types of tort reform measures adopted by states during the past three decades, caps on noneconomic damage awards have been the focus of particular interest. They have also been an issue of some debate.[8] Noneconomic

[8]Other tort reform measures adopted by states include placing caps on economic and punitive damages; abolishing the "collateral source rule" that prevents a defendant from introducing evidence that the plaintiff's losses and expenses have been paid in part by other parties such as health insurers or prevents damage awards from being reduced by the amount of any compensation plaintiffs receive from third parties; abolishing "joint and several liability" to ensure that damages are recovered from defendants in proportion to each defendant's degree of responsibility, not each defendant's ability to pay; placing limits on fees charged by plaintiffs' lawyers; imposing stricter statutes of limitations that shorten the time injured parties have to file a claim in court; and establishing pretrial screening panels to evaluate the merits of claims before proceeding to trial.

damages are awarded to plaintiffs in a medical malpractice suit to compensate for harm that is not easily quantifiable, such as pain and suffering. Proponents of caps believe that such limits can help reduce the rate of growth in malpractice insurance premiums by, among other things, helping to prevent excessive awards and overcompensation and by ensuring more consistency in jury verdicts. In contrast, opponents of these caps believe that factors other than award amounts affect malpractice insurance premiums and that caps can result in undercompensation for severely injured persons. Congress is currently considering federal tort reform legislation that includes several of the measures states have adopted, including placing caps on noneconomic and punitive damages.

Multiple Factors Have Contributed to the Increases in Medical Malpractice Premium Rates

Among the factors that have contributed to increases in medical malpractice premium rates are insurers' losses, declines in investment income, a less competitive climate, and climbing reinsurance rates. We found that increased losses appeared to be the greatest contributor to premium rate increases, but a lack of comprehensive data at the national and state levels on claims and associated losses prevented us from fully analyzing the composition and causes of those losses at the insurer level.

Rising Paid Losses Increase Insurers' Expectations of Required Premiums

In the long term the price insurers need to charge for their premiums is the sum of actual paid losses and expenses, plus a reasonable return in a competitive market.[9] Paid losses, one of the two ways that insurers define losses, are the cash payments insurers make in a given year, irrespective of the year in which the claim giving rise to the payments occurred or were reported. Most payments made in any given year are for claims that were reported in previous years. Medical malpractice insurers saw these losses begin to rise rapidly in 1998.

Short-term changes in rates—from year-to-year—are affected by incurred losses, which, in contrast to paid losses, reflect an insurer's expectations of the amounts it will have to pay on claims reported in that year and any adjustments, whether up or down, to the amounts the company expects to

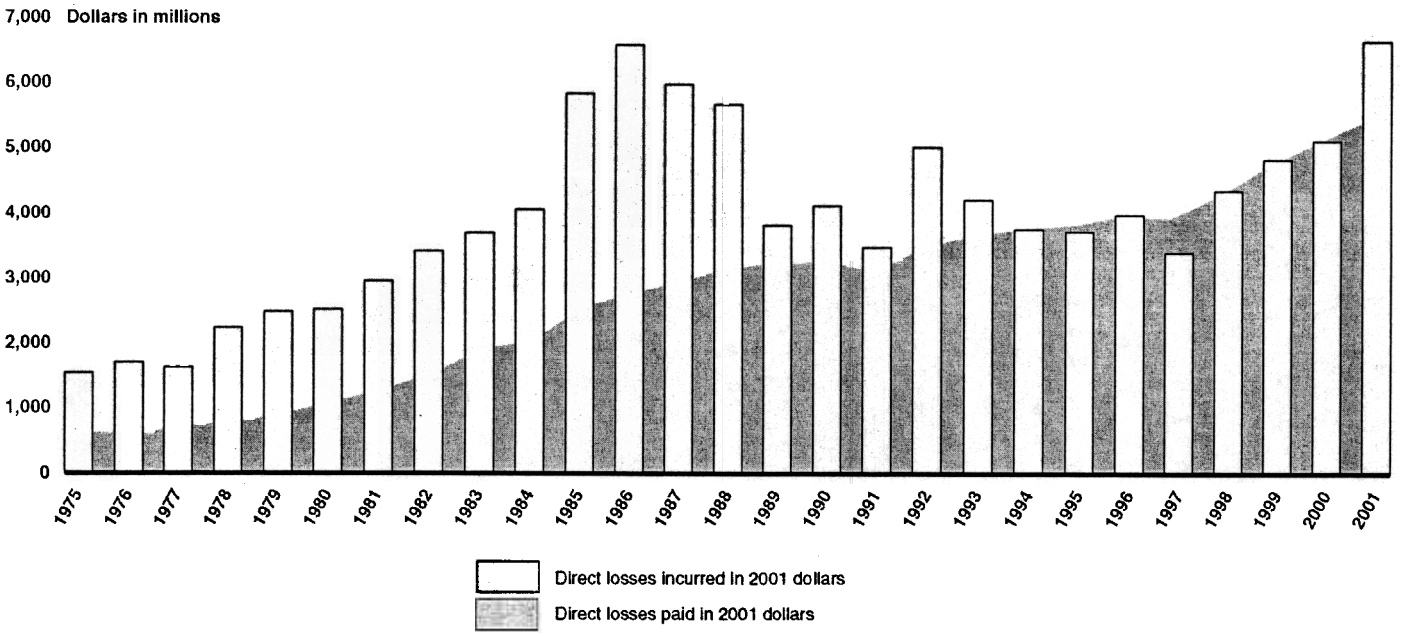
[9] We identified several factors suggesting that this market was not anticompetitive. That is, these factors suggested that insurers in this market were not charging premium rates that were inconsistent with expected losses.

pay out on claims from previous years that are still pending.[10] Incurred losses are the largest component of medical malpractice insurers' costs. For the 15 largest medical malpractice insurers in 2001—whose combined market share nationally was approximately 64.3 percent—incurred losses (including both payments to plaintiffs to resolve claims and the costs associated with defending claims) accounted for around 78 percent, on average, of the insurers' total expenses.

Figure 1 helps illustrate the relationship between incurred and paid losses and between short-term and long-term determinants of changes in premium rates. The figure shows paid and incurred losses for the national medical malpractice market from 1975 to 2001, adjusted for inflation. After adjusting for inflation, we found that the average annual increase in paid losses from 1988 to 1997 was approximately 3.0 percent but that this rate rose to 8.2 percent from 1998 through 2001. Inflation-adjusted incurred losses decreased by an average annual rate of 3.7 percent from 1988 to 1997 but increased by 18.7 percent from 1998 to 2001.

[10] That is, as more information becomes available on a particular claim, the insurer may find that the original estimate was too high or too low and must make an adjustment. If the original estimate was too high, the adjustment will decrease incurred losses, but if the original estimate was too low, the adjustment will increase them.

Figure 1. Inflation-Adjusted Paid and Incurred Losses for the National Medical Malpractice Insurance Market, 1975–2001 (Using the CPI, in 2001 dollars)



Source: GAO analysis of A.M. Best data.

The recent increases in both paid and incurred losses among our seven sample states[11] varied considerably, with some states experiencing significantly higher increases than others. From 1998 to 2001, for example, paid losses in Pennsylvania and Mississippi increased by approximately 70.9 and 142.1 percent, respectively, while paid losses in Minnesota and California increased by approximately 8.7 percent and 38.7 percent, respectively.

According to actuaries and insurers contacted with, increased losses affect premium rates in several ways. First, increasing levels of paid losses on claims reported in current or previous years can increase insurers'

[11]For analysis of the medical malpractice insurance market, we visited seven states—California, Florida, Minnesota, Mississippi, Nevada, Pennsylvania, and Texas. We selected these states because they contained a mix of characteristics, including the extent of any recently reported increases in premium rates, status as a "crisis" state according to the American Medical Association, presence of caps on noneconomic damages, state population, and aggregate loss ratios for medical malpractice insurers within the state.

estimates of what they expect to pay out on future claims. Insurers then raise premium rates to match their expectations. In addition, large losses on even one or a few individual claims can make it harder for insurers to predict the amount they might have to pay on future claims. Some insurers and actuaries we spoke with told us that when losses on claims are hard to predict, insurers will generally adopt more conservative expectations regarding losses—that is, they will assume losses will be toward the higher end of a predicted range of losses. Further, large losses on individual claims can raise plaintiffs' expectations for damages on similar claims, ultimately resulting in higher paid losses for both claims that are settled and those that go to trial. As described above, this tendency in turn can lead to higher expectations of future losses and thus to higher premium rates. Finally, an increase in the percentage of claims on which insurers must make payments can also increase the amount that insurers expect to pay on each policy, resulting in higher premium rates. That is, insurers expecting to pay out money on a high percentage of claims may charge more for all policies in order to cover the expected increases.

Declining Investment Income Has Affected Premiums

State laws restrict medical malpractice insurers to conservative investments, primarily bonds. In 2001, the 15 largest writers of medical malpractice insurance in the United States[12] invested, on average, around 79 percent of their investment assets in bonds, usually some combination of U.S. Treasury, municipal, and corporate bonds. While the performance of some bonds has surpassed that of the stock market as a whole since 2000, annual yields on selected bonds have decreased steadily since 2000. We analyzed the average investment returns of the 15 largest medical malpractice insurers in 2001 and found that the average return fell from about 5.6 percent in 2000 to an estimated 4.0 percent in 2002. However, none of the companies experienced a net loss on investments at least through 2001, the most recent year for which such data were available. Additionally, almost no medical malpractice insurers overall experienced net investment losses from 1997 to 2001. We roughly estimated that, all else held constant, the 1.6 percent decrease in average investment return from 2000 to 2002 would have resulted in an increase in premium rates of approximately 7.2 percent over the same period.

[12]As reported by A.M. Best. These insurers included a combination of commercial companies and non-profit physician-owned insurers. Some of these insurers sold more than one line of insurance, and changes in returns on investments might not be reflected equally in the premium rates of each of those lines.

Medical malpractice insurers are required by state insurance regulations to reflect expected investment income in their premium rates. That is, insurers are required to reduce their premium rates to consider the income they expect to earn on their investments. As a result, when insurers expect their returns on investments to be high, as returns were during most of the 1990s, premium rates can remain relatively low because investment income will cover a larger share of losses on claims. Conversely, when insurers expect their returns on investments to be lower—as returns have been since around 2000—premium rates rise in order to cover a larger share of losses on claims. During periods of relatively high investment income, insurers can lose money on the underwriting portion of their business but still make a profit. Although losses from medical malpractice claims and the associated expenses may exceed premium income, income from investments can still allow the insurer to operate profitably. Insurers are not allowed to increase premium rates to compensate for lower-than-expected returns on past investments but must consider only prospective income from investments.

Downward Pressure on Premium Rates Has Decreased as Profitability Has Declined

Since 1999, the profitability of the medical malpractice insurance market as a whole has declined—even with increasing premium rates—causing some large insurers to pull out of the market in some states or even nationwide. With fewer insurers offering this insurance, there is less price competition and thus less downward pressure on premium rates. According to some industry and regulatory officials in our seven sample states, premium rates were kept from rising between 1992 and 1998, in part, by price competition, even though losses generally did rise. In some cases, premium rates actually fell. For example, during this period premium rates for obstetricians and gynecologists covered by the largest insurer in Florida—a state where these physicians are currently seeing rapid premium rate increases—actually decreased by approximately 3.1 percent. Some industry participants we spoke with told us that, in hindsight, premium rates charged by some insurers during this period might have been lower than they should have been. As a result, the premium increases that began in 1998 were actually bringing premiums more in line with insurers' losses on claims. Some industry participants also pointed out that the pricing inadequacies of the 1990s were to some extent masked by insurers' adjustments to expected losses on claims reported during the late 1980s and by their high investment income.

According to industry participants and observers, as the competitive pressures on premium rates decreased, insurers apparently were able to raise premium rates to a level more in line with their expected losses

relatively quickly and easily. That is, absent the competitive pressure that may have caused insurers to keep premium rates lower, insurers were able to raise premium rates to match their loss expectations.

Reinsurance Premium Rates Have Increased

The rising cost of reinsurance was an additional reason for the recent increases in medical malpractice premium rates in our seven sample states. Insurers in general purchase reinsurance to protect themselves against large unpredictable losses. Medical malpractice insurers, particularly smaller insurers, depend heavily on reinsurance because of the potentially high payouts on medical malpractice claims.

The Medical Malpractice Market Moves through Hard and Soft Insurance Cycles

The medical malpractice insurance market appears to roughly follow the same "hard" and "soft" cycles as the overall property-casualty insurance market. However, the cycles tend to be more volatile—that is, the swings are more extreme—because of the length of time involved in resolving medical malpractice claims and the volatility of the claims themselves. Hard markets are generally characterized by rapidly rising premium rates, tightened underwriting standards, narrowed coverage, and often by the departure of some insurers from the market. In the medical malpractice market, some market observers have characterized the period from approximately 1998 to the present as a hard market. (Previous hard markets occurred during the mid-1970s and mid-1980s.) Soft markets are characterized by slowly rising premium rates, less stringent underwriting standards, expanded coverage, and strong competition among insurers. The medical malpractice market from 1990 to 1998 has been characterized as a soft market.

States with Tort Reforms that Include Certain Noneconomic Damage Caps Had Lower Recent Growth in Malpractice Insurance Premium Rates

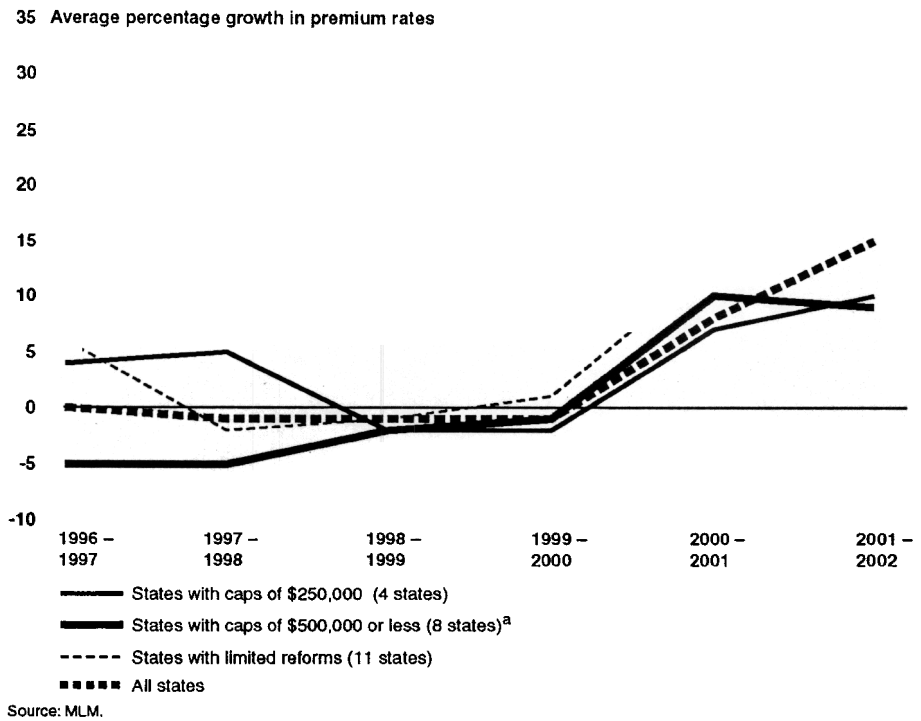
In order to constrain the rate of growth in malpractice insurance premiums, states have adopted various tort reform measures, some of which include placing caps on monetary awards for noneconomic damages. Premium rates reported for the physician specialties of general surgery, internal medicine, and obstetrics and gynecology—the only specialties for which data were available—were relatively stable on average in most states from the mid- to late 1990s and then began to rise, but more slowly among states with certain noneconomic damage caps.[13] From 1996 to 2000, average premium rates for all states changed little, as did average premium rates for states with certain caps on noneconomic damages and states with limited reforms, increasing or decreasing annually by no more than about 5 percentage points on average.[14] After 2000, premium rates began to rise across most states on average, but more slowly among states with certain noneconomic damage caps. In particular, from 2001 to 2002, the average rates of increase in the states with noneconomic damage caps of $250,000 and $500,000 or less were 10 and 9 percent, respectively, compared with 29 percent in the states with limited reforms (see fig. 2).[15]

[13]Premium rate data are reported by the Medical Liability Monitor (MLM). MLM is a private research organization that annually surveys professional liability insurance carriers in 50 states and the District of Columbia to obtain their base premium rates for the specialties of internal medicine, general surgery, and OB/GYN.

[14]We focused our analysis on those states with noneconomic damage caps as a key tort reform because such caps are included in proposed federal tort reform legislation and because published research generally finds these caps to have a greater impact on medical malpractice premium rates and claims payments than some other tort reform measures.

[15]Because research suggests that any impact of tort reforms on premiums can be expected to follow the implementation of the reforms by at least 1 year, we grouped states into their respective categories based on reforms in place as of 1995 and reviewed premium rate data for the period 1996 through 2002. Four states had noneconomic damage caps of $250,000 (California, Colorado, Montana, Utah), 8 states had noneconomic damage caps of $500,000 or less (Hawaii, Louisiana, Massachusetts, Michigan, Missouri, North Dakota, South Dakota, and Wisconsin), and 11 states had limited reforms, defined as no damage caps of any type or collateral source reforms (Arkansas, District of Columbia, Kentucky, Mississippi, Nevada, Ohio, Oklahoma, Pennsylvania, South Carolina, Vermont, and Wyoming). We categorized the remaining 28 states as "other reforms" for analysis purposes, indicating they had a noneconomic or total damage cap greater than $500,000, any punitive damage cap, or any collateral source rule reform.

Figure 2: Premium Rates for Three Physician Specialties Rose After 2000, but to a Lesser Extent in States with Noneconomic Damage Caps



Source: MLM.

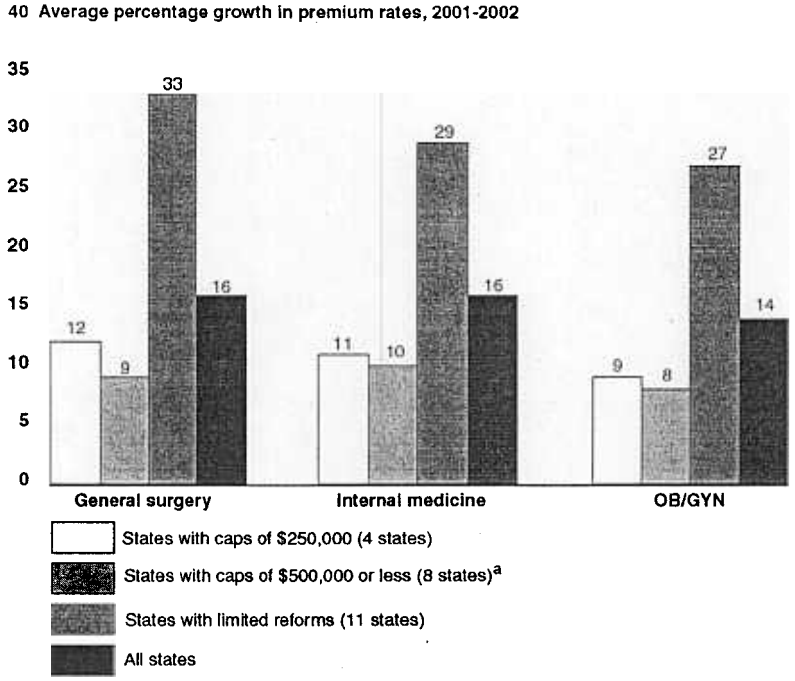
Notes: GAO analysis of MLM base premium rates, excluding discounts, rebates, and surcharges, reported for the specialties of general surgery, internal medicine, and OB/GYN.

Premiums are adjusted for inflation to 2002 dollars.

[a]This category excludes states with caps of $250,000.

The recent increases in premium rates were also lower for each reported physician specialty in the states with these noneconomic damage caps. From 2001 to 2002, the average rates of premium growth for each specialty in the states with these noneconomic damage caps were consistently lower than the growth rates in the limited reform states (see fig. 3).

Figure 3: Recent Premium Growth Was Lower for Three Physician Specialties in States with Noneconomic Damage Caps



Source: MLM.

Note: GAO analysis of MLM base premium rates, excluding discounts, rebates, and surcharges, reported for the specialties of general surgery, internal medicine, and OB/GYN.

Premiums are adjusted for inflation to 2002 dollars.

[a]This category excludes states with caps of $250,000.

Other studies have found a relationship between direct tort reforms that include noneconomic damage caps and lower rates of growth in premiums.[16] For example, in a recent analysis of malpractice premiums in states with and without certain medical malpractice tort limitations, the Congressional Budget Office (CBO) estimated that certain caps on damage awards in combination with other elements of proposed federal tort reform legislation would effectively reduce malpractice premiums on average by 25 to 30 percent over the 10-year period from 2004 through

[16]Direct reforms are limits on amounts that can be recovered in a malpractice action including caps on noneconomic or total damages, abolition of punitive damages, collateral source rule reforms, and abolition of mandatory prejudgment interest.

2013.[17] A 1997 study that assessed physician-reported malpractice premiums from 1984 through 1993 found that direct reforms, including caps on damage awards, lowered the growth in malpractice premiums within 3 years of their enactment by approximately 8 percent.[18]

Differences in malpractice premiums across states are influenced by several factors other than noneconomic damage caps. First, the manner in which damage caps are administered can influence the ability of the cap to restrain claims and thus premium costs. Some states permit injured parties to collect damages only up to the specified level of the cap regardless of the number of defendants, while other states permit injured parties to collect the full cap amount from each defendant named in a suit. Malpractice insurers informed us that imposing a separate cap on amounts recovered from each of several defendants increases total claims payouts, which can hinder the effectiveness of the cap in constraining premium growth. Second, tort reforms unrelated to caps can also affect premium and claims costs. For example, California tort reform measures include not only a $250,000 cap but also allow other collateral sources to be considered when determining how much an insurer must pay in damages and allow periodic payment of damages rather than requiring payment in a lump sum, among other measures. Malpractice insurers told us that these provisions, in addition to the cap, have helped to constrain premium growth in that state. In contrast, while Minnesota has no caps on damages, it has experienced relatively low growth in premium rates. Trial attorneys say this development is the result of mandatory prescreening requirements that have reduced claim costs, and thus premiums, by preventing some meritless claims from going to trial. Third, state laws and regulations unrelated to tort reform, such as premium rate regulations, vary widely and can influence premium rates. Finally, insurers' premium pricing decisions are affected by their losses on medical malpractice claims and income from investments, and other market conditions as we previously discussed. Because of these various factors, we could not determine the extent to which differences in premium rates across states were attributable solely to damage caps or also to these additional factors.

[17]U.S. Congress, Congressional Budget Office, *Cost Estimate: H.R. 5 – Help Efficient, Accessible, Low-cost, Timely Healthcare (HEALTH) Act of 2003* (March 2003).

[18]Daniel P. Kessler and Mark B. McClellan, "The Effects of Malpractice Pressure and Liability Reforms on Physicians' Perceptions of Medical Care," *Law and Contemporary Problems*, vol. 670, no. 1 (1997): 81-106.

Comprehensive Data on the Composition and Causes of Increased Losses Were Lacking

A lack of comprehensive data at the national and state levels on medical malpractice claims filed against various insurers and the losses associated with these claims prevented us from answering important questions about the market for medical malpractice insurance, including exactly why losses are rising over time and, as just noted, the extent to which tort reforms may have affected premium rates. For example, comprehensive data that would have allowed us to fully analyze the frequency and severity of medical malpractice claims at the insurer level on a state-by-state basis did not exist. As a result, we could not determine the extent to which increased losses were the result of an increased number of claims, larger claims, or some combination of both. In addition, data that would have allowed us to analyze how losses were divided between settlements and trial verdicts or between economic and noneconomic damages were not available. Insurers do not submit information to the National Association of Insurance Commissioners on the portion of losses paid as part of a settlement and the portion paid as the result of a trial verdict, and no other comprehensive source of such information exists. As a result, we could not analyze the effect of certain tort reforms on noneconomic losses, and thus on premium rates.

While more complete data on the insurance industry would help provide better answers to questions about how the medical malpractice insurance market is working, other data are equally important to analyzing the underlying causes of rising malpractice losses and associated costs. These data relate to factors outside the insurance industry, such as policies, practices, and outcomes in both the medical and legal arenas. However, collecting and analyzing such data were beyond the scope of our reviews.

Conclusions

As we have discussed, multiple factors, including falling investment income and rising reinsurance costs, have contributed to recent increases in premium rates in our sample states. However, we found that losses on medical malpractice claims—which make up the largest part of insurers' costs—appear to be the primary driver of rate increases in the long run. And while losses for the entire industry have shown a persistent upward trend, insurers' loss experiences have varied dramatically across our sample states, resulting in wide variations in premium rates. In addition, factors other than losses can affect premium rates in the short run, exacerbating cycles within the medical malpractice market.

We have also seen that the severe premium rate increases of the last few years followed a period of relatively stable premium rates in the early 1990s, when insurers had excess reserves and sufficient investment

income to keep rates low. But by the mid- to-late 1990s, as insurers exhausted their excess reserves and investment income fell below expectations, the profitability of malpractice insurance had declined. Regulators found that some insurers were insolvent, and in 2002 one of the two largest medical malpractice insurers, which had been selling insurance in almost every state, stopped selling medical malpractice insurance altogether. Other companies reduced the amount of insurance they sold and consolidated their markets, resulting in large rate increases in many states. It remains to be seen whether these increases will be found to have exceeded those necessary to pay for future claims losses, as they did in the 1980s.

Tort reforms, particularly those that limit noneconomic damages, have frequently been proposed as a means of controlling increases in medical malpractice insurance premium rates. While the limited available data indicate that premium rates have grown more slowly in states with tort reform laws that include certain caps on noneconomic damages, a lack of comprehensive data prevented us from determining the exact effects of these laws on premium rates. Tort reforms and other actions that reduce insurer losses below what they otherwise would have been should ultimately slow the increase in premium rates, if all else holds constant. But several years may have to pass before insurers can quantify and evaluate the effect of the laws on losses from malpractice claims and before an effect on premium rates is seen.

More time is also needed before we can determine whether the medical malpractice insurance market will continue its cycle from the current hard to a soft phase and thus are better able to understand the part the cycle itself has played in the rise in premium rates. However, any evaluation of the effect of tort reforms and cyclical behavior on premium rates requires sufficient data. In order for Congress and others to better understand conditions in the medical malpractice market and the effects of the actions that have already been or will be taken, better data need to be collected, including more comprehensive data on insurers' losses, jury verdicts in malpractice cases, and conditions in the medical industry that might affect the incidence and severity of medical malpractice suits. Without question, the absence of such data complicates the ability of insurers, regulators, and the Congress to understand current market conditions and to formulate effective, sustainable solutions.

Mr. Chairman, this concludes our prepared statement. We would be pleased to answer any questions you or other members of the subcommittee may have at this time.

Contacts and Acknowledgements

For further information regarding this testimony, please contact Richard J. Hillman at (202) 512-8678 or Kathryn G. Allen at (202) 512-7059.
Individuals from our Financial Markets and Community Investment team making key contributions to this testimony include Lawrence Cluff, Patrick Ward, Melvin Thomas, and Andrew Nelson. Individuals from our Health Care team making key contributions to this testimony include Randy DiRosa and Corey Houchins-Witt.

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COPIC INSURANCE

2003 Premiums for Colorado Physicians

Rates filed September 2002 with the Colorado Division of Insurance; approval expected for rates to take effect with renewals beginning January 2003.

Rates shown are for COPIC's claims-made reporting form insurance and take effect with your 2003 renewal. Rates shown assume:

1) Liability limits of $1 million/$3 million
2) 10% discount for participation in the Colorado Medical Society Safety Group; and
3) 10% discount for earning at least six points in COPIC's Experience Rating System (ERS).

The column "2003 Net" shows the approximate effect of the $9.6 million distribution to be credited in 2003.

Most of our insured physicians qualify for additional discounts based on practice size, number of years in practice, etc. Contact your Underwriter for more information.

MEDICAL SPECIALTY	YEAR 1	YEAR 2	YEAR 3	MATURE	2003 NET (with credits)
Administrative Medicine	$3,748	$4,636	$5,300	$5,968	$5,032
Allergy	3,748	4,636	5,300	5,968	5,032
Anesthesiology	7,440	9,352	10,788	12,220	10,306
Cardiology	10,852	13,636	15,724	17,808	15,018
— Noninvasive	6,824	8,568	9,872	11,180	9,427
Colon and Rectal Surgery	7,776	9,700	11,152	12,600	10,624
— Minor	5,596	6,996	8,044	9,092	7,669
Dermatology	5,596	6,996	8,044	9,092	7,669
Emergency Medicine	10,852	13,636	15,724	17,808	15,018
Family Practice					
— Major Surgery (Abdominal)	19,808	24,996	28,888	32,780	27,642
— Major Surgery (C-section)	10,852	13,636	15,724	17,808	15,018
— Minor Surgery	10,852	13,636	15,724	17,808	15,018
— Obstetrics	10,852	13,636	15,724	17,808	15,018
— Office/Ambulatory	6,824	8,568	9,872	11,180	9,427
Forensic Medicine	3,748	4,636	5,300	5,968	5,032
General Surgery	23,500	29,716	34,376	39,036	32,916
— Local Anesthetic	5,596	6,996	8,044	9,092	7,669
— Office Practice Only	3,748	4,636	5,300	5,968	5,032
— Office/Surgical Assisting	5,596	6,996	8,044	9,092	7,669
Geriatrics	6,824	8,568	9,872	11,180	9,427
Gynecology					
— Major Surgery	14,884	18,708	21,576	24,444	20,611
— Office Practice Only	3,748	4,636	5,300	5,968	5,032
— Office/Surgical Assisting	5,596	6,996	8,044	9,092	7,669
Hand Surgery	14,884	18,708	21,576	24,444	20,611
Hospitalist	6,824	8,568	9,872	11,180	9,427
Hyperbaric Medicine	5,596	6,996	8,044	9,092	7,669
Internal Medicine not otherwise classified	6,824	8,568	9,872	11,180	9,427
— Endocrinology	6,824	8,568	9,872	11,180	9,427
— Gastroenterology	7,776	9,700	11,152	12,600	10,624
— Hematology	6,824	8,568	9,872	11,180	9,427
— Infectious Disease	6,824	8,568	9,872	11,180	9,427
— Neoplastic Disease	6,824	8,568	9,872	11,180	9,427
— Nephrology	6,824	8,568	9,872	11,180	9,427
— Pulmonary Disease	6,824	8,568	9,872	11,180	9,427
— Rheumatology	6,824	8,568	9,872	11,180	9,427

* Because of its unique nature, claims-made reporting form insurance allows COPIC to offer reduced premiums for the first three years of coverage. These reductions account for the fact that claims tend to develop over a number of years rather than immediately. Year 1 is priced at approximately 60% of mature premium; Year 2 is priced at approximately 75% of mature premium; and Year 3 is priced at approximately 90% of mature premium.

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With credits

MEDICAL SPECIALTY	YEAR 1	YEAR 2	YEAR 3	MATURE	2003 NET
Neonatology	5,596	6,996	8,044	9,092	7,669
Neurology (including child)	11,468	14,420	16,636	18,852	15,897
Neurosurgery	50,920	64,664	74,968	85,276	71,905
— Office Practice Only	3,748	4,636	5,300	5,968	5,032
— Office/Surgical Assisting	5,596	6,996	8,044	9,092	7,669
Nuclear Medicine	3,748	4,636	5,300	5,968	5,032
Obstetrics & Gynecology	21,040	26,572	30,720	34,868	29,400
Occupational Medicine	3,748	4,636	5,300	5,968	5,032
Ophthalmology	3,748	4,636	5,300	5,968	5,032
Oral Surgery	5,596	6,996	8,044	9,092	7,669
Orthopaedics	19,808	24,996	28,888	32,780	27,642
— Office Practice Only	3,748	4,636	5,300	5,968	5,032
— Office/Surgical Assisting	5,596	6,996	8,044	9,092	7,669
Osteopathic Manipulative Medicine	3,748	4,636	5,300	5,968	5,032
Otorhinolaryngology	14,884	18,708	21,576	24,444	20,611
— Minor	5,596	6,996	8,044	9,092	7,669
— Office Practice Only	3,748	4,636	5,300	5,968	5,032
Pathology	7,776	9,700	11,152	12,600	10,624
Pediatrics	5,596	6,996	8,044	9,092	7,669
Physical Medicine and Rehabilitation	3,748	4,636	5,300	5,968	5,032
Plastic Surgery	22,604	28,492	32,912	37,328	31,476
Podiatry	5,596	6,996	8,044	9,092	7,669
Preventive Medicine	5,596	6,996	8,044	9,092	7,669
Psychiatry	3,748	4,636	5,300	5,968	5,032
Radiation Oncology	7,776	9,700	11,152	12,600	10,624
Radiology — Diagnostic/Invasive	7,776	9,700	11,152	12,600	10,624
Thoracic Surgery	27,528	34,784	40,228	45,664	38,507
— Office Practice Only	3,748	4,636	5,300	5,968	5,032
— Office/Surgical Assisting	5,596	6,996	8,044	9,092	7,669
Toxicology	3,748	4,636	5,300	5,968	5,032
Urology	14,884	18,708	21,576	24,444	20,611
— Office Practice Only	3,748	4,636	5,300	5,968	5,032
— Office/Surgical Assisting	5,596	6,996	8,044	9,092	7,669
Vascular Surgery	27,528	34,784	40,228	45,664	38,507
— Office/Surgical Assisting	5,596	6,996	8,044	9,092	7,669
Volunteer Physician Program**	n/a	n/a	n/a	n/a	n/a

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** The COPIC Trust pays the premium for physicians insured under this program.