WYOMING TRIAL LAWYERS ASSOCIATION

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Dear Members of the Wyoming Health Care Commission:

The Wyoming Trial Lawyers Association appreciates the large task the commission will be undertaking in addressing the many complex issues regarding health care in Wyoming. We look forward to working with you. We will be providing you with information during the course of your work but please feel free to call on us if there are additional materials you would like or questions that we can answer.

The cost of medical malpractice insurance and the effect the rates have on some doctors in Wyoming is of concern and as you know the topic of legislative interim study and legislative consideration during the last session. Tort reform is often suggested as a solution for problems with increasing premiums.

The Wyoming Trial Lawyers Association has been involved for many years in gathering and reviewing the facts available to assess the truth about these issues. Members of the Wyoming Trial Lawyers Association involved in opposing "tort reform" feel a responsibility to advocate for patients, your friends and neighbors, parents and children, who have or will suffer a significant injury or death as a result of negligence.

Although there is information that is simply unavailable, the information we do have includes the following:

1. Historically, insurance premium rates increase significantly when interest rates and investment income decreases dramatically. We have seen this occur again in 2001 and 2002. When similar circumstances existed in the mid-1980s, the National Association of Attorneys General conducted a study and concluded that there is little evidence that making the changes in the tort system proposed by the federal government and the insurance industry will prevent a similar "crisis" in the future given the cyclical nature of the insurance industry.

2. A review of the rate information filed with the Wyoming Insurance Department for The Doctors Company, which insured the majority of Wyoming doctors until OHIC started writing in the state, reveals that from 1992 through 2000, base rates only increased a total of 3.5% for the entire nine year period. That level of increase is significantly below cost of living increases and increases in the cost of health care during the same period.

3. The number of claims and severity of claims have remained stable in Wyoming over the past seven years during which we have gathered data. The average amount paid per

claim (which includes economic damages) is less than the cap on noneconomic damages of $250,000 which has been proposed.

4. Numerous insurance insiders, including an OHIC representative testifying in Wyoming, have admitted that tort reform will not lower rates. A recent study by Weiss Ratings, Inc. reached the same conclusion.

5. Although there are people who claim that the drastic tort reform enacted in California in the mid-1970s (MICRA) has worked to stabilize rates, the full story paints a different picture. After California enacted MICRA, insurance rates continued to skyrocket. It was after insurance reform was enacted (Proposition 103) in 1988 that rates stabilized.

6. A medical malpractice case will not go to trial in Wyoming unless a qualified expert states the doctor's treatment of the patient fell below the standard of care. The success of Wyoming doctors at trial (winning 26 out of 31 cases since 1989, with no million dollar verdicts) most likely reflects the benefit of the doubt Wyoming jurors give their local doctors. We don't need tort reform in Wyoming. All the information we have gathered shows that Wyoming jurors are conservative. If a large verdict does result, there is little doubt that it will be reasonable under the circumstances of the case.

7. Sadly, medical errors do occur, and some patients are permanently injured or killed. According to a study released by the National Academy of Sciences Institute of Medicine, more people are killed by medical errors in hospitals each year than die from car accidents, breast cancer or AIDS. If a lawyer files a medical malpractice lawsuit lacking in merit, our system has procedures to address the problem. We have not been provided evidence there are many such claims filed. It is time for everyone to admit that medical errors cause most medical liability claims, not the legal profession.

The Wyoming legislature has used good judgment in refusing to amend the Wyoming Constitution to allow caps on damages. Justice should not be denied to injured patients particularly when it will not reduce malpractice premium costs. Other solutions – solutions that will work – must be found. One may be to find ways to assist doctors in those communities in which physician income does not justify paying the rates. Another action to consider is more stringent review of insurance industry practices to determine whether sudden, significant increases in premiums are justified for doctors who have not been found liable for claims, and to determine whether there are ways to address the cycles caused by changes in investment income. It also makes sense to study whether Wyoming doctors could form a group similar to ALPS, which has helped stabilize attorney malpractice rates. Finally, legislation should be enacted that requires complete reporting of claim settlement information. If legislators are going to be asked to consider changes to our legal system, they are entitled to receive accurate, complete data and should not be expected to base decisions on incomplete, anecdotal information. The citizens of

Wyoming deserve nothing less.

Sincerely,



Thomas B. Jubin
Wyoming Trial Lawyers Association

AN ANALYSIS OF THE CAUSES OF THE CURRENT CRISIS OF UNAVAILABILITY AND UNAFFORDABILITY OF LIABILITY INSURANCE

Prepared for The National Association of Attorneys General

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SYNOPSIS

This report has been prepared to provide Attorneys General with an analysis of the commonly suggested causes of the current crisis of unavailability and unaffordability of liability insurance. The purpose of this report is not to advocate for or against changes in the tort system. Rather, so that any such debate can be based on accurate facts, this report was prepared to provide a review of the factual basis the following propositions:

1. That the property/casualty insurance industry is in terrible financial straits;

2. That there has been a drastic increase in the number and size of present and future liability claims;

3. That the increased claims are the cause of the current problems in availability and affordability of liability insurance;

4. That the most effective way to resolve the present crisis and prevent future problems of availability and affordability is to change our tort system to limit the number and size of liability claims.

These propositions constitute the basic elements of the call by both the insurance industry and the federal government for massive changes in our civil justice system to end the current insurance "crisis". Based on a careful analysis of the facts relied on by the insurance industry and the federal government to support their arguments, this report concludes there is little evidence to support these propositions.

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Based on our analysis, a more accurate description of the causes of the current crisis is as follows:

1. When the financial situation of the property/casualty insurance industry is reviewed in the same fashion as that of other large industries, rather than based on reserve and accounting requirements used for statutory reporting purposes, the companies are continuing to make a profit and are recovering very effectively from their recent price wars;

2. There has been no evidence produced which shows the existence of an "explosion" in either numbers of lawsuits filed or size of claims paid. To the contrary, any growth in these areas appears to be both moderate and predictable. Assertions of "explosions" are overstated and based on a misuse of statistics;

3. The present "crisis" of unavailability and unaffordability is not caused by the civil justice system but by the unrestrained price cutting recently undertaken by the industry when it attempted to obtain as much new business as possible to invest premiums at the then high interest rates;

4. There is little evidence that making the changes in the tort system proposed by the federal government and the insurance industry will prevent a similar "crisis" in the future given the cyclical nature of the insurance industry.

The report concludes by recommending that each Attorney General carefully scrutinize the facts surrounding the present "crisis" in his or her state before he or she joins in any rush to significantly alter the civil justice system. While periodic review of both the fairness and efficiency of our system of compensating victims is appropriate, it should not be automatically assumed that adoption of the proposed changes in

our tort system will have any significant impact on assisting consumers and businesses to obtain more affordable liability insurance. In addition, such a review is best conducted on a state level where the common law of tort recovery originates and where rests the primary regulatory jurisdiction over insurance.

I. INTRODUCTION

Summary and Purpose

In recent months, liability insurance for many organizations, municipalities and professionals has increased in cost tremendously, has been drastically restricted in its coverage, or has become unavailable at any price. The property/casualty insurance industry argues strongly that the costs of insuring against many forms of liability are too great, and that change in the system of civil justice to limit the rights of victims is the only solution. This same conclusion was reached by the February, 1986 federal government "Report of the Tort Policy Working Group on the Causes, Extent and Policy Implications of the Current Crisis in Insurance Availability and Affordability" (hereinafter "Justice Department Report" produced by an inter-agency working group, and recently mailed to each Attorney General

Clearly our federal and state court systems are not perfect; there is always room for improvement in the efficiency and fairness of our civil justice scheme. It is both important and valuable periodically to evaluate the development of the common law of negligence, strict liability and damages to guarantee that both plaintiffs' and defendants' rights are being protected.

Yet it is also important to approach change in this system carefully and methodically, and with full understanding of the perceived problems we seek to solve. Change in the civil justice system would have long-term and far reaching consequences. Before instituting any such change in an effort to solve the "insurance crisis", one must first determine whether the civil justice system is in fact responsible for the crisis. If the civil justice system is found not to be at fault for the crisis, we may yet wish to institute civil justice reform for other reasons. If this is the case, however, the urgency of reform evaporates, and proposed reforms can be evaluated deliberately and without the undue haste brought about by panic and a "crisis" situation.

Therefore, to place this debate in its proper context and to assist Attorneys General in evaluating independently the causes of the current problems of unavailability and unaffordability of liability insurance, we have prepared the following analysis of the major conclusions of the Justice Department Report and the insurance industry position. Since the states enjoy primary and virtually complete responsibility for the regulation of insurance, state Attorneys General have an important role to play in the solution of the "crisis".

Our purpose is not to advocate one position or another in the debate over the need for further regulation of the

insurance industry or for changes in the civil justice system. We believe, however, that it is crucial that any such debate be based upon an accurate statement of the facts. This paper is intended to help provide such accuracy, and thereby to promote a calm and rational discussion of the issues.

Suggested Causes for the Current "Crisis"

The position of the Justice Department Report, the insurance industry and others who argue that the present insurance crisis is caused by a "tort explosion" depends to a large extent upon the truth of at least the following four propositions:

1. The property/casualty insurance industry is in terrible financial straits and therefore cannot continue to provide liability coverage without enormous premium increases, reductions in coverage and cancellations.

2. There have been vast increases in the number and size of liability claims which the property/casualty insurance industry has had or will have to pay.

3. These increased claims are the cause of the insurance industry's financial plight, and therefore of the availability and affordability problems.

4. The most effective way to address the current "crisis" in insurance availability and affordability and to avoid drastic premium increases and sudden cancellations, therefore, is to change legal rules to limit the numbers and size of liability claims which insurers will have to pay.

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Important Underlying Issues

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Instead, changes in the law of tort liability or damages will simply relocate these costs so that a larger proportion of them rest with victims rather than with defendants or with society as a whole as costs are spread by defendants' insurance. Whether a new allocation of costs may be desirable is a question which should be considered on its own merits and based on the specific facts in each state, not one to be decided as an unexamined side effect of efforts to resolve problems with insurance coverage. In this light, for example, an increase in the size of jury awards ought not be automatically viewed as a problem needing correction simply because it may signal a need for insurance premium increases; instead, it could be considered as an indication of increased justice to victims, or increased spreading of risk within society.

Important factual questions are also raised by the prospect that changes in insurance payouts are linked to real-world changes rather than merely to changes in the law of tort liability or damages. For example, are serious product-caused injuries actually becoming more widespread, rather than simply more widely compensated? Are we seeing an increase in the severity of injuries, or of more reckless and unsafe conduct by defendants? Are jury verdicts proportionately scaled to seriousness of injury? What proportion of injuries are left uncompensated by the tort system, and has this proportion changed over time? Such issues must be kept in mind throughout any evaluation of the current situation.

II. DISCUSSION

QUESTION #1:

IS THE PROPERTY-CASUALTY INSURANCE INDUSTRY IN TERRIBLE STRAITS FINANCIALLY?

Underwriting losses are frequently cited by the insurance industry and others as evidence of the industry's financial difficulties. The Justice Department Report states that the property-casualty industry has, in the past two years, suffered "significant underwriting losses $21 billion in 1984; $25 billion in 1985) which have limited its ability to offer as much insurance as its customers desire, and have made it reluctant to insure high risk activities which may expose it to further substantial underwriting losses." (Justice Department Report, at 1). But there have been numerous criticisms of both the significance and accuracy of these underwriting loss figures. Critics have asserted that if the insurance industry's financial picture is reviewed in the same way as the financial soundness of other businesses, the picture isn't nearly so gloomy.

The Limitations of Underwriting Results As A Measure of Profitability

Underwriting results for insurance companies are the measure of the difference between premiums paid in and claims

(and claims adjusting expenses) paid out in a given period. Losses result when claims and expenses exceed premiums; gains occur when the reverse is true.

It is crucial to realize, however, that underwriting results are only one of two sources of property/casualty income; the other source is investment gain. Investment gain allows a company to "...have net income even though its premium revenues alone are not large enough to cover claims and expenses." Statement of Johnny C. Finch, Senior Associate Director, General Government Division, U.S. General Accounting Office, Before The Subcommittee on Oversight, Committee on Ways and Means, House of Representatives, on Profitability of the Property/Casualty Insurance Industry, at 2 (April 28, 1986) [hereinafter "Finch Statement"]

There are several sources of investment gains which are available to property/casualty insurers, as they are to all businesses, and which are not accounted for in underwriting result figures. When these sources of gain are included in calculations, the property/casualty industry shows substantial profits.

First, figures on underwriting gain or loss do not take into account the income insurers have actually earned in any given year by investing premiums. In lines of insurance business like liability coverage, there is generally a long lag

between the payment of the premium for a period of coverage and the ultimate payment of a claim incurred during that period (this is often referred to as a long "tail" For example, for an act of medical malpractice taking place in 1975, a final judgment might not be entered and a claim actually paid by the malpractice insurer until 1980. The insurer would therefore invest the 1975 premium and earn interest on it for five years before payout would occur. Thus, in such long-tailed lines as liability insurance, there is a great opportunity for investment gains on premium income. The federal government's General Accounting Office (GAO) has noted, for example, that while medical malpractice coverage represented less than 2% of total property/casualty insurance premium in 1984-85, its premiums accounted for approximately 6% of the industry's investment gains. Likewise, while general liability coverage represented about 6% of total industry premium, this 6% accounted for 14% of the industry's investment gains. (Statement of William J. Anderson, Director, General Government Division, U.S. General Accounting Office, Before the Subcommittee on Oversight Committee on Ways and Means, House of Representatives, on Profitability of the Property/Casualty Insurance Industry, at 11 (March 3, 1986) [hereinafter "Anderson Statement"] The property/casualty industry had investment income of $19.7 billion in 1985. (Best's Insurance

Management Report, at 1 (December 30, 1985) [hereinafter "Best's I"]; Insurance Information Institute, The Executive Letter Special Report, at 2 (January 13, 1986) [hereinafter "III Report"])

Second, investment can produce income not only in the form of interest and dividends, but also in the form of realization of capital gains on assets which have appreciated in value and which are then sold. The Insurance Services Organization ISO) and the Insurance Information Institute III) have stated that the property/casualty industry realized capital gains of $5.3 billion in 1985. ISO, Insurer Profitability -- The Facts, at 22-23 February, 1986) [hereinafter "Insurer Profitability" ; III Report, at 2; Best's Review, Property/Casualty Insurance Edition, at 6 February, 1986), citing the III [hereinafter "Best's II"]). This is not surprising, given the character of the property/casualty industry's investment portfolio. Today, the industry is heavily invested in bonds; for example, in 1984, 54% of the industry's portfolio was invested in bonds. (Best's Aggregate & Averages, Property Casualty, at 2 (1985 Since bonds have fixed rates of interest, bonds purchased while interest rates are high appreciate in value as interest rates later fall. In the face of the falling interest rates of the last 5 years, many of the property/casualty industry's assets have appreciated tremendously. Realization of significant

amounts of these gains while interest rates are low and value is high is therefore to be expected from a reasonable investor.[1/] Yet, realized capital gain is also not taken into account when underwriting loss is calculated.

The insurance industry itself calculates that when underwriting loss is set off by investment income and realized capital gains alone, a net gain of $51.4 billion for the decade 1975-1984 results. (Insurer Profitability, at 31). The GAO has calculated the same figure for the later decade 1976-1985 as a net gain of $51 billion (Finch Statement, at 5).

Third, in large part because of its practice of failing to discount reserves, the property casualty industry has rarely paid any federal income tax.[2/] The industry routinely receives federal income tax credits, which it then uses to offset federal taxes in future or past years. Thus, in any given year the property/casualty industry

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1/ While it is true that bonds become correspondingly less valuable in times of very high interest rates, such as the late 1970's and early 1980's, insurers gave no indication during that period of high income that the decreased bond value created financial difficulties for the industry. It is only now, when these assets have appreciated, that a "crisis" is said to be occuring.

2/ The insurance industry is entitled to federal income tax deductions for its reserves. To the extent that these reserves are considered too large because of a failure to discount, the tax deduction is overstated as well.

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source estimates the net gain for 1985 at $2 billion. (Best's Review, Property/Casualty Insurance Edition, at 14 (May, 1986) [hereinafter "Best's III"]). Thus, while analysts may differ slightly as to the exact value of, or relationship between, the various sources of revenue described above, there is no doubt that the bottom line is decidedly positive.

In addition, the GAO has recommended to Congress that two other sources of income be added in calculating the industry's profitability. These changes significantly increase profit figures. First, the GAO recommends that investment gains include unrealized as well as realized capital gains. Thus, if an insurer's investments have appreciated in value, that increased value would be taken into account when calculating the company's financial status. The GAO reasons that ...it is well within a company's control to manage its investment portfolio so as to realize these gains while the investments are profitable." Finch Statement, at 5). The property/casualty industry registered $1.2 billion in unrealized capital gains in 1985. (Best's I, at 1; Best's at 6). While analysts may differ as to what proportion of unrealized gains should be included in profit calculations, it is clear that at least some of these gains should be reflected, and equally clear that insurance industry calculations of profit and loss omit these gains completely.

The Artificiality of Underwriting Results

if, at the end of the year in question, the following two events will come to pass: all policies will be cancelled (so that the insurer cannot rely on a continuing stream of income) and all claims filed or expected to be filed during the year will be paid in full. Critics such as NICO have argued that while such a "worst case scenario" may be an appropriate way for state regulators to protect their citizens from insurer insolvency, it is not an appropriate basis upon which to estimate reserve liabilities in calculating the actual profitability of the industry. NICO, And Now the Real Facts, A Response To The Insurance Services Office's "Insurer Profitability -- The Facts", at 4-5 [hereinafter "Response"]).

Instead, critics have recommended that property/casualty reserves be estimated in a more realistic fashion, taking into account the ability of the reserves to earn investment income n future years. Reserve estimates could thus be smaller, or "discounted," since a smaller reserve amount invested now would produce the larger, full amount needed later when claims come due. The GAO has criticized the failure of insurers to discount their reserves.[3/]

3/ It should be noted that critics have also asserted that, at times, the industry overestimates its reserves, and that reserves should therefore be smaller even independently of discounting. (See, e.g., NICO Newsletter, at 10).

(Gandhi Address, at 8). NICO has estimated that this modification and one other related adjustment would by themselves increase the 1985 net gain figure by $5.5 billion. (Response, at 5).

CONCLUSION #1:

THE PROPERTY/CASUALTY INDUSTRY IS IN ADEQUATE AND IMPROVING FINANCIAL CONDITION

Based on the foregoing discussion, it is clear that to obtain a complete and accurate picture of the current profitability of the property/casualty insurance industry, one must look beyond underwriting income alone. The inadequacy of underwriting income alone as a measure of profitability is wel illustrated by this calculation of the GAO:

> ... while the property/casualty companies had about $46 billion in underwriting losses from 1975 through 1984, they also had about $121 billion in investment gains during this period, resulting in a net gain of about $75 billion for those years. (Anderson Statement, at 4).

And although from 1980-84, the industry registered a $45 billion underwriting loss, $82 billion in investment gain resulted in a net gain to the industry for those years of $37 billion. (Finch Statement, at 5). Thus, by virtually any of the standard measures of profitability, the property/casualty industry is far from the brink of disaster. Given this more accurate picture of industry profitability, it is not

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investors..." after lesser gains in 1984. (King, Best's II, at 21). In the first quarter of 1986, the same pattern has emerged: property/casualty stocks are up by 26%, again about twice the increase in the market. Since 1975, the property/casualty insurance stock index has risen more than 500%, which is more than five times the rise of the Dow. (Real Facts, at 4). And over the last 16 years, Best's points out that "...the Property/Casualty index was the growth leader with [a growth rate of] 524%." (King, Best's III, at 21). Finally, of the 17 property/casualty stocks which constitute Best's index, only one declined in value in 1985. Of the 30 property/casualty stocks Best's follows, only three declined in value in 1985. (Id., at 99)

Thus, there is considerable evidence that the property/casualty insurance industry, far from being in dire financial straits, is in fact doing quite well financially. The emphasis on a need for change in the civil justice system to rescue the insurance industry from financial problems is therefore entirely misplaced.

QUESTION #2:

HAVE THERE BEEN VAST INCREASES IN THE NUMBER AND SIZE OF LIABILITY CLAIMS WHICH THE PROPERTY-CASUALTY INSURANCE INDUSTRY HAS HAD OR WILL HAVE TO PAY?

The insurance industry, in seeking to effect changes in the civil justice system, argues that the major source of any financial reversals the industry may be suffering is an "explosion" in litigation and in the size of tort judgments. An argument of this sort is also made by the Justice Department Report

> [A] major factor underlying the availability/ affordability crisis is the insurance industry's attempt to bring premiums quickly back into line with rapidly growing liability risks. The high -- and in some areas unaffordable -- insurance premiums reflect the fact that tort law is now placing a massive compensation burden on the private sector. (Justice Department Report, at 3).

This "explosion" means, according to the industry and the Justice Department Report, that losses are too unpredictably high for companies to sell insurance, or to sell it without drastic premium increases. Yet the statistics presented in the Justice Department Report do not demonstrate a "litigation explosion" nor does the report acknowledge the contrary evidence contained in existing research on litigation and litigation expenditure.

The Justice Department Report cites as evidence of a litigation explosion" increases in the average size of jury verdicts, and increases in the number of large awards. Id., at

35-52). A cause of both these changes is argued to be the growth of punitive damages and other noneconomic compensation. Id., at 39). The Justice Department Report also seeks to justify its conclusions by purporting to document an increase in the number of law suits filed. (Id., at 45). What follows is an analysis of the statistical basis for these conclusions.

The Frequency of Litigation

The overall picture of our society which the Justice Department Report appears to paint is that society is becoming increasingly litigious. Individuals are said to rush to the court house in the event of any misfortune. As an example of sudden litigiousness of tort victims, the Justice Department Report states: "[T]he number of product liability cases filed in federal district courts has increased from 1,579 in 1974 to 13,554 in 1985, a 758% increase. There is no reason to believe that the state courts have not witnessed a similar dramatic increase in the number of product liability claims." (Justice Department Report, at 45)

However, there is now substantial reason to believe that state courts have not witnessed such a dramatic increase. A statistical study recently released by the National Center for State Courts shows that in fact claims filed in state courts have not increased significantly over the last several years.

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represented in the Report. For example, State Government News cites National Center of State Courts data showing a 20% increase in liability claims over the last 7 years. ("The Liability Crisis: Who's to Blame" at 4, 5 (March/April 1986)). These increases, however, do not even approach the several hundred-fold increases in state court litigation implied by the Justice Department Report, and there is no indication that such moderate rises would not have been predictable in earlier years. Researchers do not consider such increases as "explosive", nor supportive of a conclusion that society is becoming increasingly litigious. (Galanter, Reading the Landscape of Disputes: What We Know and Don't Know (and Think We Know) About Our Allegedly Contentious and Litigious Society, 31 U.C.L.A. L. Rev. 4 (1983) [hereinafter "Galanter"])

To put the amount of litigation in its proper context it is important to understand that only a very small fraction of injurious experiences result in litigation.[4/] Even where victims are aware that they have been tortiously injured, many choose not to make any type of claim, and many who do

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4/ "Any empirical discussion of the frequency of litigation must employ a baseline -- some measure of the number of opportunities to use the courts against which actual filing rates can be compared. . . If one were concerned with medical malpractice litigation, for example, it would be inadequate merely to note an increase in the number of cases filed. One would want to relate this to rates of professional contacts which might generate lawsuits." (Trubek, Grossman, Felstiner, Kritzer & Sarat, Summary of Principle Findings, 1 Civil Litigation Research Project: Final Report, at S-17 (1983)).

make claims do not pursue these claims to the courts. (See, e.g., Galanter, at 11; Trubek & Sarat, at 83-86). A study of hospital records in the mid-1970's showed that only 1 in 10 instances of medical malpractice led to a claim, and of those, only 40% resulted in payment. One researcher concludes from this that even under the most generous assumptions about litigation rates, the social cost of medical malpractice far exceeds the cost of medical malpractice claims. (Danzon, Medical Malpractice: Theory, Evidence, and Public Policy, at 25 (Harvard University Press, 1985 [hereinafter "Danzon"]

The Asserted "Explosion" in the Compensation of Tort Victims

The statistics presented by the Justice Department Report on jury awards at first glance seem to indicate that there has been a huge increase in the average size of jury awards for medical malpractice and products liability claims: "According to a jury verdict reporting service, between 1975 and 1985 the average medical malpractice jury verdict increased $220,018 to $1,017,716 and the average product liability jury verdict increased from $393,580 to $1,850,452." (Justice Department Report, at 2-3).

To determine the impact of these figures on overall increases in claims payments by insurance companies for tort liability, however, the relationship between jury awards and overall claims paid by insurance companies to victims of

negligence must be reviewed. Only a tiny proportion (5-10%) of tort cases filed result in jury verdicts[5/] (Galanter, at 27; Trubek & Sarat, at 89); the vast majority are settled, settlements are overall considerably smaller than verdicts. (See Danzon, at 31, showing that for a sample of cases closed in 1974 and 1976, the average verdict award was 4 times the size of the average settlement award). Even for those few claims which result in jury verdicts for the plaintiff, verdicts are frequently overturned, reduced on appeal, reduced by judges or trimmed in post-verdict settlements. Thus, the average actual compensation to tort victims is certainly much smaller than the average jury verdict.

It is also important to realize that to determine the typical award to a tort victim, it is necessary to consider the median award, not merely the average or mean figure used by the Justice Department Report. (See, e.g., Daniels, Punitive Damages: A Storm on the Horizon? Preliminary Report of the Punitive Damages Project, at 13 (prepared for delivery at the American Bar Foundation Fellows Seminar, February 8, 1986) [hereinafter "Daniels"]; Localio, Variations on $962,258: The Misuse of Data on Medical Malpractice, 13 Law, Med. & Health Care 126 (1985)). A median figure is the midpoint figure for

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5/ Note also that the number of jury trials has actually been decreasing in recent years. (See, e.g., Shanley & Peterson, Civil Jury Verdicts in San Francisco and Cook County, 1959-1980 (Rand Corp., 1983)).

awards; it therefore shows the maximum compensation received in at least half of all jury verdicts. For jury awards, the median is much smaller than the average, which can be significantly influenced upward by a few very large claims. example, in Cook County in 1983, the average award for reported verdicts was $137,350 whereas the median award was only $8,800. 87.7% of cases had awards lower than the average. (Daniels, at 13 In fact, although evidence shows the average award has been increasing, the median jury award has not increased more than the rate of inflation, which shows that at least half of all jury awards still involve very small amounts. See, e.g., Rand Corp., Institute for Civil Justice: An Overview of the First Five Program Years, at 23 1985) [hereinafter "Overview"]).

Given the relatively small percent of total claims paid which is represented by jury verdicts, the large inflation shown in the average jury verdict may not accurately describe what is happening to overall tort claim payments by insurance companies. Large verdicts may be peculiar to the types of cases, perhaps more serious cases, which are likely to go to trial, and the vast majority of cases which do not reach a verdict may not show the effects of such large inflation Several studies have in fact shown that cases which go to trial tend to be more serious than cases which settle. Danzon, at

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The Failure To Demonstrate An Explosion In The Number of "Large" Verdicts

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representative of an overall increase in "large" verdicts. The "large" verdict is thus the means used by proponents of changes in tort law to suggest that victims are being overcompensated, and has become the target of many proposed tort law changes. The Justice Department Report adopts this same approach, stating:

> "[T]he percentage rate of increase of verdicts is far higher for large verdicts than for small or medium-size verdicts. Since a significant distinguishing factor between large and small or medium-size verdicts is that large verdicts tend to be composed to a far greater extent of non-economic damages, this strongly suggests that non-economic damages play a major role in the explosive growth of large verdicts." (Justice Department Report, at 39).

In an attempt to show that there has been a disproportionate increase in very large verdicts, the Justice Department Report cites two statistics: first, that the number of $1 million medical malpractice verdicts increased 1200% from 1975 to 1984; and second, that excluding $1 million dollar verdicts lowers the increase in average jury awards from 363% to 26% over 10 years. (Justice Department Report, at 39).

The Justice Department Report's reliance on the million dollar verdict presents an inaccurate picture of the true significance of these figures for two basic reasons. First, a large rise in the number of $1 million verdicts could as easily be attributable to the existance of a number of verdicts just under $1 million in 1975 as to some unexplained growth at the

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The Impact of Punitive Damage Awards On Tort Claim Payouts

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particularly in the area of non-economic damages such as pain and suffering, mental anguish and punitive damages." (Justice Department Report at 52). When the underlying data is carefully reviewed there is little support for this assertion. The punitive damage statistics presented as an example of the explosion in noneconomic compensation drastically overstate the significance of punitive damage awards.

First, punitive damages are awarded infrequently. (Daniels, at 10; See also, Institute for Civil Justice, Summary of Research Results on the Tort Liability System, Statement by Deborah R. Hensler, prepared for Senate Committee on Commerce, Science, and Transportation, at 4 (February 1986), [hereinafter "Hensler Statement"]. For example, ___ County jury-awards included punitive damages in only 2.2% of cases. (Daniels, at 10-11). Punitive damages are even less frequently awarded in either products liability or medical malpractice cases. (See, e.g., Daniels, at 15; Hensler Statement, at 4; Landes and Posner, A Positive Economic Analysis of Products Liability, 14 J. Legal Stud. 535, 565 (1985) [hereinafter "Product Liability"]).7/ In addition,

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7/ For example, in New York City, of the 48 products liability cases reported in 1981-83 which went to trial none included a punitive award. Of the 318 medical malpractice cases reported, only 1 included a punitive award. (Daniels, at Table 6). Landes and Posner conclude: "Punitive damages are not routinely awarded in products liability caes, but only where there are circumstances of aggravation. These include reckless indifference to safety, gross negligence, or concealment by the manufacturer of the dangerousness of his product from consumers." (Product Liability, at 564).

in many jurisdictions insurance companies cannot legally pay punitive damage awards. In those states where they may, they typically can do so only if such awards are assessed through vicarious liability. (See, e.g., Annot., 16 A.L.R. 4th 11 (1982); Sales and Cole, Punitive Damages, 37 Vand. L. Rev. 117, 1163 n. 209 (1984)

Second, the average punitive damage award statistics cited by the Justice Department Report ignore the effects of post-verdict reductions through appeal, remittitur, and settlement. In fact, studies show that post-verdict reduction is particularly significant for punitive damage awards. One study found that punitive damages were upheld on appeal in only 4 out of 10 products liability cases. (Product Liability, at 565 These findings are confirmed by the full analysis of the data performed by the Institute for Civil Justice, which found that the final amount of punitive damage jury awards actually paid is on average only 50% of the original jury award. (Hensler Statement, at 4

Third, the statistics presented compare average punitive awards in Cook County only, which has an unusually large number of $1 million verdicts. (Daniels, at 17 These statistics are therefore not representative of Illinois, much less the country as a whole. (See Daniels, at 1-6). Daniels finds tremendous variability in both the frequency and size of punitive damage awards among the many different sites studied. Id., at 10, 13

Fourth, the increases in average punitive awards shown by the Justice Department Report statistics are not useful because so few punitive damage awards are tallied (e.g., 23 in a 5 year period) that the results are very susceptible to the effects of one large award in a five year period. Whereas the Justice Department Report cites the average Cook County punitive damage award for the period 1980-84 ($489,000), the median award for the period was only $20,000. (Peterson , Punitive Damages: Preliminary Empirical Findings (Rand Corp., 1985)). Other reports not discussed by the Justice Department Report show that overall, both the size and number of punitive damage awards remain moderate. (Daniels, at 19).

Finally, the number of punitive damage awards is such a small percent of all awards that any observed increase in the size of such awards could have no major impact on the overall increase in tort claims payments. Thus, punitive damages in tort claims should be of limited concern to insurance companies.8/

8/ Interestingly, research shows that one of the largest sources of punitive damage awards is bad faith claims against insurance companies. ("[P]unitive award[s] are clustered, typically, in a small set of causes of action: personal violence, fraud, false arrest, and insurance bad faith." Daniels, at 14). This clearly is of great concern to the companies, though they do not argue that such awards are unjustified, or that the awards fail to provide an efficient deterrent to future unfair claims settlement practice.

The Evidence On Pain and Suffering Awards

The largest category of noneconomic damage is awards for pain and suffering. The Justice Department Report states: "Such non-economic damages are inherently open-ended and subjective, and therefore, easily susceptible to dramatic inflation." (Justice Department Report, at 39). No evidence is presented by the Justice Department Report or the industry to show that such awards are increasing. The statistic cited by the Justice Department Report shows that "large" awards contain a higher proportion of noneconomic damages than smaller awards, but no evidence is presented as to whether or not this percentage 54% is increasing or decreasing. Such information is necessary to determine whether in fact pain and suffering awards have been increasing in size. It is reasonable to assume that if the data showed any significant increase in these awards it would have been documented in the Justice Department Report. Finally, it is important to remember that whereas punitive damages serve a deterrent purpose, pain and suffering awards represent compensation for real and very serious damage to an injured victim.

CONCLUSION #2:

THE EVIDENCE SHOWS NO VAST OR EXPLOSIVE INCREASES IN CLAIMS OR PAYMENTS TO VICTIMS

The Justice Department Report has not provided any significant evidence that society has suddenly become much more

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QUESTION #3:

ARE INCREASED CLAIMS THE CAUSE OF THE INSURANCE INDUSTRY'S FINANCIAL PLIGHT, AND THEREFORE OF THE AVAILABILITY AND AFFORDABILITY PROBLEMS?

To understand how to remedy the current problems in insurance cost and availability, it is essential that we understand what has actually caused these problems. Altering the common law system of civil justice is a drastic step. To take such action as a "cure" for the current "crisis" would be a mistake if in fact the character of the civil justice system has little or no responsibility for the high cost and unavailability of liability insurance.

What, then, is the reason for the recent drastic increases in liability insurance premiums, the reductions in coverage, and the policy cancellations? As discussed in the previous section, statistics show that there has not been the sort of explosion in litigation or payments to victims in the recent past which some have reported. The GAO and others are confident that past premiums, when combined with investment income, were adequate by and large to cover past claims and allow for a comfortable profit.10/

10/ 1984 was apparently one of the least profitable of recent years for the property/casualty industry. It should be noted, however, that results for later periods show an upturn in profitability (see Conclusion #1 above). In addition, due to losses reported for tax purposes in 1984, the industry garnered federal tax credits of $1.9 billion. (Anderson Statement, at 6).

Thus, it seems clear that past experience has not provoked the current problems. Even the industry insists that current premium increases are not intended to compensate for past "losses". (Insurer Profitability, at 9).

Rather, the industry argues that it has merely set premiums at levels adequate to pay future claims, which it argues will burgeon due to the litigation "explosion." (Id.). The Justice Department Report agrees, noting that "[t]he insurance availability/affordability crisis is one symptom -- albeit the most dramatic and acute sympton -- of the dislocations and problems generated by a malfunctioning tort system." (Justice Department Report, at 3). But if, as is shown above, future claims are not likely to be burgeoning, then why are insurers seeking to increase premiums?

The answer lies in the industry itself.

There is considerable evidence, much of it from the insurance industry, that the industry itself bears much, if not all, of the responsibility for the current pricing and availability problems. The attractiveness of liability lines due to the opportunities they offer to invest premium income has been discussed above. It is undeniable that in the late 1970's and early 1980's, the property-casualty insurance industry engaged in "years of substantial underpricing. (Insurance Services Office, 1985, A Critical Year, at 5 (May, 1985) [hereinafter "Critical Year"]). During this period,

interest rates were increasing rapidly and peaking at their highest point this century (21.5% in late 1980 and early 1981). Thus, "In an attempt to generate cash flow for investment, insurers competed aggressively for premium dollars, knocking prices more and more out of line with loss costs." (Critical Year, at 4). Another insurance industry publication, quoted in the Justice Department Report, stated:

> For the better part of seven years, the insurance industry has been engaged in a brutal price war. During the early 1980's, the price for commercial insurance was decreasing, sometimes sharply, as insurers vied for premium dollars to invest at th high interest rates then in effect... (Justice Department Report, at 22, quoting ISO, Financial Condition of the Insurance Industry -- An Update (1985)).

As noted in Business Week, "[t]he rate hikes ... result largely from the insurance industry's own mismanagement." (Glaberson and Farrell, Commentary, Business Week, at 24 April 21, 1986 The GAO noted that the industry's ... strategy has been to sacrifice underwriting gains for investment gains." Finch Statement, at 3). To summarize succinctly, and in the words of the industry itself, "[p]ricing that failed to keep pace with loss costs and lagged the nation's overall economic growth has brought insurers into their current predicament." (A Critical Year, at 6).

Thus, while premiums were priced adequately to pay for losses during periods of high interest rates, those premiums may have been inadequate to pay for losses once interest rates

CONCLUSION #3:

THE CYCLICAL NATURE OF THE INDUSTRY ITSELF, AND NOT ANY CHANGE IN TORT CLAIMS, IS LARGELY RESPONSIBLE FOR THE CURRENT "CRISIS"

The insurance industry, rather than any sudden change in liability suits or recoveries, clearly bears great responsibility for the recent premium hikes and cancellations. Efforts to prevent these undesirable events in the future are therefore likely to fail if they do not focus on the industry's cyclical pricing practices of the past. Given these facts, an exclusive and unquestioning focus on altering the civil justice system is inappropriate, and is likely to be a futile means of addressing the problems in the insurance market today.

QUESTION #4:

IS THE WAY TO AVOID DRASTIC PREMIUM INCREASES AND SUDDEN CANCELLATIONS, THEREFORE, TO CHANGE LEGAL RULES TO LIMIT THE NUMBERS AND SIZE OF LIABILITY CLAIMS WHICH INSURERS WILL HAVE TO PAY?

As stated above, changes to the tort system may or may not be appropriate. However, to see such changes as a cure to current and future liability insurance "crises" presupposes the conclusion that increased claims play the primary role in increased premiums and cancellations. To the contrary, the evidence of a strong cyclical pattern in the industry, independent of claim size or frequency, renders it unlikely that changes in claim patterns alone can avoid another "crisis".

First, an examination of the insurance industry shows that its booms and busts over the years exhibit a cyclical pattern. As the GAO has described it:

> [w]e ... believe that the industry is particularly subject to profit and loss cycles ... Unlike most other industries the property/casualty insurance industry is flexible with respect to capacity. When times are good, insurance companies can increase their capacity, take varied and greater risks, and generally lower their premium rates in order to achieve a greater market share. This results in a change from favorable premium profit margins to unfavorable margins, resulting in profit and loss cycles. Thus, the industry pricing strategy can result in financial cyclicity. (Anderson Statement, at 7).

This cycling is tied to interest rates and insurance industry sales tactics rather than to loss or claims patterns. Thus, altering these claims patterns may do absolutely nothing toward preventing the cycle from bottoming out again at some future point.

Second, during the last low point in the cycle in the mid-1970's, similar arguments were made by the insurance industry concerning the need for a narrowing in the civil justice system. However, in many of those localities where significant changes were made, the current cycle has still resulted in numerous availability and affordability problems. For example, Pennsylvania passed the Political Subdivision Tort Claims Act of 1978 in response to problems in cost and availability of liability insurance for municipalities. The Act, among other things, bars all tort claims against local government which do not fall within certain exceptions, caps recoveries within those exceptions, reduces compensation by any amount available from collateral sources, and requires that injury be permanent to be actionable. Yet municipalities in Pennsylvania are apparently suffering under the same drastic premium increases as elsewhere. (Titelman, The "Crisis" of Cost and Lack of Availability of Liability Insurance, 16 Barrister 4, at 41 (Winter 1985-86)

In addition, in 1985, a study of medical malpractice insurance partially funded by the U.S. Health Care Financing Administration HCFA) concluded that

> Almost all states enacted legislation in response to the rapid rise in malpractice insurance premiums which occurred during the mid-1970's ... The empirical results of the study presented here give no indication that individual state legislative actions, or actions taken collectively, had their intended effects on premiums.

(Sloan, State Responses to the Malpractice Insurance "Crisis" of the 1970's: An Empirical Assessment, 9 Journal of Health Politics, Policy and Law 629 (1985) Thus, there is as yet no evidence that narrowing of the civil justice system does avoid skyrocketing premiums and cancellations when the industry reaches the bottom of its cycle; the available evidence, in contrast, seems to show just the opposite.

CONCLUSION #4:

CHANGES IN THE CIVIL JUSTICE SYSTEM ARE NOT LIKELY TO SOLVE THE CURRENT OR FUTURE PROBLEMS IN AVAILABILITY AND AFFORDABILITY OF LIABILITY INSURANCE

Insurers today are arguing and lobbying vociferously for changes in the civil justice system, yet the industry will make no commitments to restrain premium increases or cancellations if particular changes in the civil justice system are enacted. Serious questions are raised above concerning the very existance of a litigation "explosion" and the connection between any such "explosion" and current insurance problems. In addition, evidence indicates that cycling of insurance rates takes place independently of claims levels. Given this, enactment of statutory changes designed to narrow common law rights of recovery with no commitment by insurers that premiums will stabilize as a result is a greater risk than even the insurers themselves would consider prudent.

III. CONCLUSION

After careful review of the major assumptions and conclusions underlying the Justice Department Report, it is clear that they are substantially unsupported by the facts. The facts do not bear out the allegations of an "explosion" litigation or in claim size, nor do they bear out the allegations of a financial disaster suffered by property/casualty insurers today. They finally do not support any correlation between the current crisis in availability affordability of insurance and such a litigation "explosion." Instead, the available data indicate that the causes of, and therefore the solutions to, the current crisis lie with the insurance industry itself. Thus, to the extent that civil justice reform may be desirable, it would be for reasons entirely separate from the liability insurance "crisis". The rush to put such civil justice changes in place is therefore uncalled-for and potentially quite harmful, since these changes would remain in place, while providing little relief from any cyclical "crisis" period the insurance industry might pass through in the future. In particular, the implementation of such changes at the federal level would create inflexibility and would eliminate states' abilities to make their own judgments as to the real causes and proper solutions to the current unavailability and unaffordability of liability insurance.

RATE CHANGES FOR THE DOCTORS COMPANY IN WYOMING
1992 - 2002

According to Wyoming Insurance Department information, there were no medical malpractice rate increases between 1992 and 1995. The Doctors Company rate increase history since 1995 is as follows:

Year	Rate Increase
1995	7.8%
1998	1%
1999	-5.3%
2001	10%
2002	28.8%

The total rate increase between 1992 and 2002 has been 42.3%, an average of approximately 4% per year.



For Immediate Release
June 2, 2003

Contact:
Joanne Doroshow, 212/267-2801

Industry Insiders Admit – And History Shows: Tort Reform Will Not Lower Insurance Rates

Representative of the Ohio Health Insurance Company testifying before the Wyoming Legislature:
Tort reform will not lower rates. (*Casper Star Tribune*, May 4, 2003)

Medical Assurance Co. of Mississippi:
"[T]ort reform does not provide a magical 'silver-bullet' that will immediately affect medical malpractice insurance rates." (Medical Assurance Co. of Mississippi, September 2002)

Patricia Costante, chairman and CEO of the MIIX Group of Insurance Companies:
When asked by New Jersey Assemblyman Paul D'Amato whether, if caps are enacted in New Jersey, her insurance company will not raise premiums and will, in fact, reduce them, she said, "No, we're not telling you that." (Meeting of the New Jersey Assembly Joint Committee of Banking & Insurance and Health & Human Services on Medical Malpractice, June 3, 2002)

American Insurance Association:
"[T]he insurance industry never promised that tort reform would achieve specific premium savings." (American Insurance Association Press Release, March 13, 2002)

Sherman Joyce, President, American Tort Reform Association:
"We wouldn't tell you or anyone that the reason to pass tort reform would be to reduce insurance rates." (*Liability Week*, July 19, 1999)

Victor Schwartz, General Counsel, American Tort Reform Association:
"[M]any tort reform advocates do not contend that restricting litigation will lower insurance rates, and 'I've never said that in 30 years.'" (*Business Insurance*, July 19, 1999)

Dick Marquardt, Washington Insurance Commissioner:
It was "impossible to attribute stable insurance rates to tort-law changes or the damages cap," since rates also improved in states that did not pass tort reform. (*The Seattle Times,* May 16, 1991)

Chairman of Great American West Insurance Company:
"[T]ort reform 'will not eliminate the market dynamics that lead to insurance cycles,' and 'we must not over-promise—or even imply—that insurance cycles will end when civil justice reform begins.' (*Liability Week*, Jan. 19, 1988.)

Connecticut State Lawmaker:
"[T]he insurance industry now says [tort reform] measures will have no effect on insurance rates. We have been disappointed by the response of the insurance industry. The reforms we passed should have led to rate reductions because we made it more difficult to recover, or set limits on recovery. But this hasn't happened." (*UPI*, March 9, 1987)

State Farm Insurance Company (Kansas):
"[W]e believe the effect of tort reform on our book of business would be small. ... [T]he loss savings resulting from the non-economic cap will not exceed 1% of our total indemnity losses.... [I]n our sample of liability claims, no claim was found that would have been affected by the joint and several restriction." And any savings due to alternative payment methods would be "negligible." (Letter from Robert J. Nagel, Assistant Vice President, State Filings Division, to Ray Rather, Kansas Insurance Department, Oct. 21, 1986, at 1-2.)

Aetna Casualty and Surety Co. (Florida):
After Florida enacted what Aetna Casualty and Surety Co. characterized as "full-fledged tort reform," including a $450,000 cap on non-economic damages, Aetna did a study of cases it had recently closed and concluded that Florida's tort reforms would not effect Aetna's rates. Aetna explained that "the review of the actual data submitted on these cases indicated no reduction of cost." (Aetna Casualty & Sur. Co., Commercial Ins. Div., Bodily Injury Claim Cost Impact of Florida Tort Law Change, at 2 (Aug. 8, 1986))

St. Paul (Florida):
St. Paul's found "a total effect of about 1% savings" from Florida's 1986 tort reforms, but that even this 1% might be inflated. St. Paul concluded that "the noneconomic cap of $450,000, joint and several liability on the noneconomic damages, and mandatory structured settlements on losses above $250,000 will produce little or no savings to the tort system as it pertains to medical malpractice." (St. Paul Fire & Marine Ins. Co., Medical Professional Liability, State of Florida–Addendum at 1 (1986))

General Accident Insurance Company (Washington State):
"Given that liability losses constitute such a low proportion of business owners' losses, GA feels it is prudent to continue with its original proposal of a 10 percent increase in base rates." (*The Seattle Times*, July 1, 1986. The *Times* wrote that "the highly touted tort-reform legislation enacted by the Legislature early this year is not lowering liability-insurance rates as promised, according to preliminary filings made with the state insurance commissioner.")

Allstate Insurance Company (Washington State)
In asking for a 22% rate increase following passage of tort reform in Washington State, including a cap on all damage awards, the company said, "our proposed rate would not be measurably affected by the tort reform legislation." (*The Seattle Times*, July 1, 1986)

St. Paul (Washington State):
After enactment of the 1986 Washington tort reforms, St. Paul said that the limit on plaintiffs' lawyers fees "probably will have no effect on loss costs," and that "a 'cap' can become a target in smaller dollar cases, thus actually working to increase costs. We do not have the data that would allow us to project the actual probable effect in either direction." (Letter from Richard W. Tongen, Executive Vice President, St. Paul Fire and Marine Ins. Co., to Richard G. Marquardt, Washington Insurance Commissioner, June 12, 1986, Attachment at 1.

Great American West Insurance Company (Washington State)
After the 1986 Washington tort reforms, the Great American West Insurance Company said that on the basis of its own study, "it does not appear that the 'tort reform' law will serve to decrease our losses, but instead it potentially could increase our liability. We elect at this point, however, not to make an upward adjustment in the indications to reflect the impact of the 'tort reform' law." (Letter from Kevin J. Kelley, Director of Actuarial, to Norman Figon, Rate Analyst, Washington Insurance Department, April 23, 1986, at 1)

Basil Badley, chief Washington State lobbyist for the insurance industry:
"Legislators and consumers were mistaken from the beginning if they thought tort reform was going to lessen personal liability insurance costs." (*Seattle Times,* July 1, 1986)

Iowa Municipalities:
In 1983, Iowa limited joint and several liability in order to limit the liability of cities and counties. Yet in 1985, 41 Iowa counties had their liability insurance cancelled within a 30-day period, leading former Iowa Senate Majority Leader Lowell Junkins, who had led the fight for tort reform, to change his position, and to urge other legislators not to make the same mistake. (Interview with Lowell Junkins in Orlando, Fla., Jan. 20, 1986)

Pennsylvania Municipalities:
A blue-ribbon Pennsylvania commission found that the cost of municipal liability insurance rose sharply in the mid-1980's even in those states which had capped damages against municipalities after the mid-1970's insurance crisis. (Report, Recommendations, and Summary of Testimony: Hearing on Municipal Liability Insurance, Sept. 24, 1985, before Pennsylvania Local Gov't Comm'n 3-4, Nov. 1985)

New Mexico Municipalities
In 1976 New Mexico capped municipal liability at $500,000 per person, and in 1982 it eliminated joint and several liability. Yet premiums rose sharply for New Mexico municipalities during the mid-1980's insurance crisis just as they did in states without caps on municipal liability. (*Roswell Daily Record,* May 15, 1986)

Vanderbilt University:
A regression analysis conducted by Vanderbilt University economics professor Frank Sloan found that caps on economic damages enacted after the mid 1970's insurance crisis had no effect on insurance premiums. (Sloan, "State Responses to Malpractice Insurance Crisis of the 1970's: An Empirical Assessment," 9 *Journal of Health Politics, Policy & Law* 629-46 (1985))

THE FOUNDATION FOR TAXPAYER AND CONSUMER RIGHTS

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For Immediate Release
December 5, 2002

News Release

Contact: Doug Heller
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California's Second-Largest Medical Malpractice Insurer Withdraws 15.6% Rate Hike After Group Challenges Increase

Prop 103 Blocks $2,000/Year Rate Increase for 9,100 California Doctors

Santa Monica, CA — Facing a hearing requested by consumer advocates under Prop. 103, California's second-largest medical malpractice insurer has withdrawn its application to raise its 2003 premiums for doctors by 15.6%. The Foundation for Taxpayer and Consumer Rights (FTCR), the citizen group that challenged the SCPIE Holdings rate increase, said its action would save the 9,100 SCPIE-insured doctors in California $2,000 each . The group also noted that medical malpractice hikes have caused controversy around the country.

"Rather than open its books to independent scrutiny and justify its request for a double-digit rate hike, as it is required to do under Prop. 103, this insurance company apparently decided it didn't need a rate increase after all," said Harvey Rosenfield, President of FTCR and author of Prop. 103, the 1988 voter-approved insurance reform initiative. "This is just as we suspected. If other states had the kind of stringent rate regulation required by Prop. 103, there would be no medical malpractice 'crisis' in America today," he said.

Doctors Should Examine Insurance Industry Rather Than Attack Their Patients

The FTCR challenge to the SCPIE rate request comes as the insurance industry has initiated massive rate increases nationwide in medical malpractice coverage – the insurance physicians and hospitals buy to protect themselves in the event they injure or maim patients. (According to a Harvard study more than 150,000 Americans die each year from medical mistakes).

Insurers have blamed malpractice lawsuits for the rate hikes, and enlisted doctors in a propaganda campaign to win laws limiting the right of victims of medical mistakes to sue doctors. This year, Nevada and Mississippi passed such laws at the behest of the insurers and doctors. And President Bush has signaled that a federal law to limit the rights of medical malpractice victims to receive full compensation will be a top congressional priority in the coming year.

The model for these efforts is, ironically, a California law, the Medical Injury Compensation Reform Act (MICRA). It was passed after a similar 'crisis' in 1976. Studies have shown that MICRA did not reduce insurance premiums for doctors. Indeed, premiums did not drop until after the passage of Proposition 103 by California voters in 1988.

"For too long, lawsuits have been improperly blamed for the rise in insurance costs, while the insurance companies quietly requested their own rate hikes, hoping no one would notice. Prop 103 allows us to shine a spotlight on the entire industry, and we intend to continue our efforts to expose this hypocrisy," said Daniel Zohar of the Zohar Law Firm in Los Angeles, a private firm assisting the FTCR with its rate challenges. "The insurance industry increases premiums on doctors, limits payments to injured patients

and walks away with the profit. By forcing insurers to open their books, doctors will find that their real battle is with the insurance companies, not the legal system."

Consumer advocates say that scrutiny of insurers' financial data shows that the companies are hiking premiums to offset stock market losses, not rising claims. A recent study by FTCR showed that major insurers lost billions of dollars after investing in corporate stocks and bonds, such as Enron and WorldCom.

Stringent Regulation of Insurance Companies Lowers Rates

Passed by California voters despite a record $80 million campaign against it, Proposition 103 gives state regulators and the public powerful tools to investigate and limit the insurance industry's rates and practices.

SCPIE, located in Los Angeles, filed an application for its rate increase on September 16, 2002, as it is required to do under Proposition 103. This was its third rate hike in three years and its fifth in seven years. FTCR reviewed the application with national experts and requested a hearing under Insurance Code section 1861.05, the Prop. 103 provision which allows members of the public to challenge rate increases. Under that law, the California Department of Insurance (CDI) must grant a hearing for a challenge to any increase above 15% for commercial lines of insurance (7.5% for personal). CDI granted the hearing on November 22. SCPIE then withdrew its request on November 27.

"Clearly the eighteen million dollars SCPIE wanted to add to doctors' premiums was unnecessary," said FTCR's senior consumer advocate Doug Heller. "This should be a wake-up call to the nation's doctors, who have accepted the insurers' propaganda and joined with these companies in an assault of their own patients. It is certainly strange that doctors in California have never challenged a malpractice rate increase –leaving it to a consumer group to protect them against the rapacious insurance industry. Doctors should examine the insurance industry and its propaganda more carefully before backing the industry attack on patients' rights. To not do so is moral malpractice."

"Caps on recovery of damages not only been bad for injured patients, it has done nothing to keep malpractice insurers from continuing to raise rates for doctors. Only a strong regulatory system and a strong regulator will control medical malpractice insurance rates," said Heller.

FTCR Litigation Director Pamela Pressley and Los Angeles attorney Daniel Zohar represented FTCR.

WEISS RATINGS INC.

Medical Malpractice Caps Fail to Prevent Premium Increases, According to Weiss Ratings Study

Physicians in States with Caps Suffer 48% Increase in Median Annual Premiums Even While Insurers Enjoy Slowdown in Payouts

PALM BEACH GARDENS, Fla., June 2, 2003 - Caps on non-economic damages have failed to prevent sharp increases in medical malpractice insurance premiums, even though insurers enjoyed a slowdown in their payouts, according to a white paper released today by Weiss Ratings, Inc., the nation's leading independent provider of ratings and analyses of financial services companies, mutual funds, and stocks.

In reviewing the impact that tort reform has had on both medical malpractice (med mal) premiums paid by doctors in three high-risk specialties[1] and insurers' claim payout levels[2] between 1991 and 2002, Weiss noted the following trends:

Physicians continued to suffer a rapid increase in med mal premiums despite caps: In 19 states that implemented caps during the 12-year period, physicians suffered a 48.2 percent jump in median premiums, from $20,414 in 1991 to $30,246 in 2002. However, surprisingly, in 32 states *without* caps[3], the pace of increase was actually somewhat *slower*, as premiums rose by only 35.9 percent, from $22,118 to $30,056.

At the same time, among the 19 states with caps, only two of the states, or 10.5 percent, experienced flat or declining med mal premiums. In contrast, states without caps were actually *better* able to contain premium rate increases, with six, or 18.7 percent, experiencing stable or declining trends.

Meanwhile, the insurers enjoyed slowed increases in claims payout levels: The median payout in states without caps surged 71.3 percent, from $87,553 in 1991 to $150,000 in 2002. In contrast, the median payout grew by only 37.8 percent in states with caps, from $79,798 to $110,000. Likewise, in states without caps, the median payout for the entire 12-year period was $116,297, ranging from $75,000 to $220,000, while the median payout for states with caps was 15.7 percent lower, or $98,079, ranging from $50,000 to $190,000.

"Tort reform has failed to address the problem of surging medical malpractice premiums, despite the fact that insurers have benefited from a slowdown in the growth of claims," said Martin D. Weiss, chairman of Weiss Ratings, Inc. "The escalating medical malpractice crisis will not be resolved until the industry and regulators address the other, apparently more powerful, factors driving premiums higher."

Other Factors Contributing to the Med Mal Crisis

Weiss identified six factors driving the increase in medical malpractice rates, each of which may be exerting a greater impact on premiums than the presence or absence of caps:

- ***The medical inflation rate:*** Medical costs have risen 75% since 1991.
- ***The insurance business cycle:*** The property and casualty industry suffered a 12-year "soft" period through 1999, during which marketing goals often superceded prudent underwriting practices and decision-makers typically relied too heavily on high investment income to make up for losing operations. In an attempt to catch up, insurers have tightened underwriting standards and raised premiums.
- ***The need to shore up reserves for policies in force:*** Med mal insurers have been consistently under-reserving since 1997—to the tune of $4.6 billion through December 31, 2001. The only way to shore up reserves is to increase premiums.
- ***A decline in investment income:*** Investment income declined by 23 percent in 2001 and then *another* 2.5 percent in 2002, which is particularly critical for lines of business like med mal since the duration of claims payouts typically spans several years.
- ***Financial safety:*** Based on the Weiss Safety Ratings, 34.4 percent of the nation's med mal insurers are vulnerable to financial difficulties, compared to 23.9 percent of the property and casualty insurance industry as a whole. To restore their financial health, many med mal insurers will remain under pressure to increase rates despite new laws to cap payouts.
- ***Supply and demand for coverage:*** The number of med mal carriers increased through 1997 to 274, but has since fallen to 247 in 2002.

Weiss Recommendations

Although the implementation of non-economic caps has resulted in a slowdown in payout increases for insurers, most insurers have not passed those savings on to physicians, continuing to jack up premiums due to other powerful pressures. Thus, caps have been ineffective in reducing medical malpractice premiums for medical professionals. To adequately address this national crisis, Weiss suggests several comprehensive steps, including:

- ***Legislators*** should put all proposals for non-economic damage caps on hold until convincing evidence can be produced to demonstrate a true benefit to doctors in the form of reduced med mal costs;
- ***insurance companies*** must never again allow marketing to divert or pervert prudent actuarial analysis and planning; and
- the ***medical profession*** must assume more responsibility for policing itself.

Weiss Ratings issues safety ratings on more than 15,000 financial institutions, including HMOs, life

and health insurers, Blue Cross Blue Shield plans, property and casualty insurers, banks, and brokers. Weiss also rates the risk-adjusted performance of more than 12,000 mutual funds and more than 7,000 stocks. Weiss Ratings is the only major rating agency that receives no compensation from the companies it rates. Revenues are derived strictly from sales of its products to consumers, businesses, and libraries.

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1 Medical malpractice premiums paid by doctors in three high-risk specialties: internal medicine, general surgery, and obstetrics/gynecology. Data source: Medical Liability Monitor.

2 Data source: National Practitioner Data Bank

3 For the purposes of this analysis, the District of Columbia is being referred to as a "state" since it effectively operates as such with regard to insurance regulation.

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Note to Editors: Copies of *Medical Malpractice Caps: The Impact of Non-Economic Damage Caps on Physician Premiums, Claims Payout Levels, and Availability of Coverage* are available upon request.



Medical Malpractice Caps

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

by

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June 2, 2003

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Based in Palm Beach Gardens, Fla., Weiss Ratings issues safety ratings on more than 15,000 financial institutions, including life and health insurers, HMOs, Blue Cross Blue Shield plans, property and casualty insurers, banks, and brokers. Weiss also rates the risk-adjusted performance of more than 11,000 mutual funds and 7,000 stocks. Weiss Ratings is the only major rating agency that receives no compensation from the companies it rates. Revenues are derived strictly from sales of its products to consumers, businesses, and libraries

Medical Malpractice Caps

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

Executive Summary

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

Caps did reduce the burden on insurers...

In states with caps, the median payout between 1991 and 2002 was 15.7% lower than the median in states without caps, despite the fact that many states did not impose the caps until late in the 12-year period.

- Moreover, in states with caps, the payouts increased by only 37.8% from 1991 to 2002, while the rate of increase in states without caps was 71.3%, or nearly double.

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

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

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

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

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

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

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

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

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

Recommendations:

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

Introduction

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

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

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

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

*Caps are adjusted annually for inflation.

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

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

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

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

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

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

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

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

Caps do reduce the burden on insurers...

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

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

- **Growth in payouts slowed substantially.** The median payout in the 32 states without caps increased by 71.3%, from $87,553 in 1991 to $150,000 in 2002. In contrast, payouts in the 19 states with caps increased at a far slower pace—by only 37.8%, from $79,798 in 1991 to $110,000 in 2002.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Part 2. Other Factors Driving Up Med Mal Premiums

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

1. Medical Cost Inflation

The medical inflation rate in the 12-year period was 75%[4] (i.e., $1 of medical expenses in 1991 cost $1.75 in 2002). However, throughout the country, insurers had a general tendency to let their premium increases lag behind the pace of medical inflation. This was most likely due to the extended soft market experienced by the entire property and casualty insurance industry in the 1990s, explained below.

2. The Cyclical Nature of the Insurance Market

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

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

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

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

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

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

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

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

4. A decline in investment income

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

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

  Now, aggravating their difficulties, they also needed to compensate for stock market losses. With falling stock prices and declining interest rates, investment income[5] for the entire property/casualty industry fell 23% in 2001 compared to 2000, and then *another* 2.5% in 2002; and we must assume that med mal insurers suffered a similar decline. Indeed, investment income is particularly critical for lines of business like med mal where the duration of claims payouts typically span several years.

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

5. Financial Safety

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

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

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

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

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

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

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

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

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

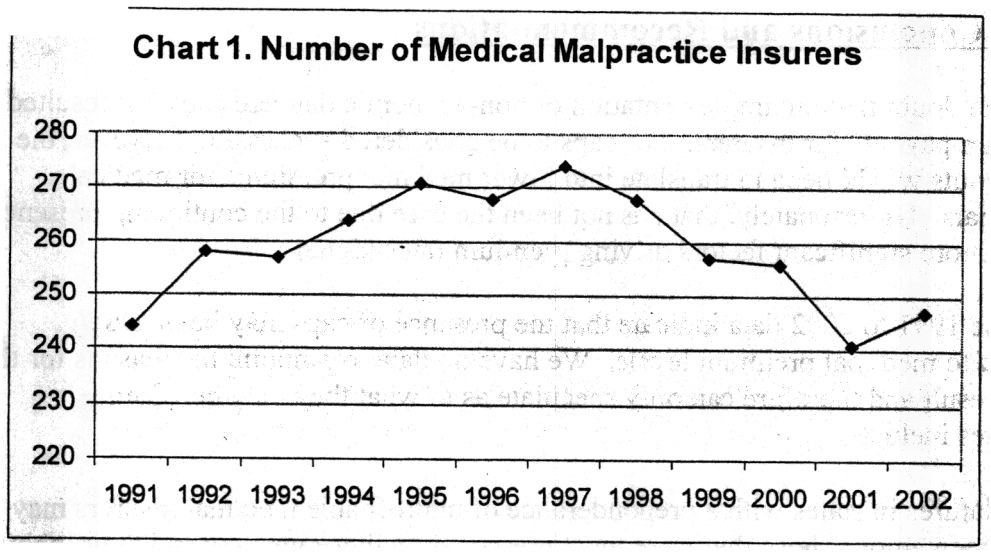
Weiss Safety Rating Category	2003 Med Mal Insurers	1999 Med Mal Insurers
Secure	65.5%	69.0%
Vulnerable	34.4%	31.0%

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

6. The Supply and Demand of Coverage

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

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



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

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

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

Part 3. Conclusions and Recommendations

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

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

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

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

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

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

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

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

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

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

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

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

We recommend the following steps:

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

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

For many years, we have warned that rather than evaluating the property and casualty business based on total profits (including investment income), the focus should be on underwriting profits and losses, independent of investment income.[6] Had our warnings been heeded, premium rate increases may have risen gradually over time, rather than jumping suddenly during an already-painful bear market.

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

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

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

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

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

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

Appendix 1

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

State	Year Imposed	Amount of Cap ($000)	1991 Median Payout ($)	2002 Median Payout ($)	% Change 1991 to 2002	1991 Median Premium ($)	2002 Median Premium ($)	% Change 1991 to 2002
Alaska	1997	500	166,246	165,000	-.7	N/A	27,940	N/A
California	1975	250	42,160	67,500	60.1	20,354	30,430	49.5
Colorado	1998	250	33,249	100,000	200.8	22,678	33,651	48.4
Hawaii	1976	375	39,899	250,000	526.6	23,334	25,756	10.4
Idaho	1990	682	29,259	100,000	241.8	N/A	14,199	N/A
Indiana	1990	1,000	46,549	50,000	7.4	N/A	22,886	N/A
Kansas	1994	250	99,747	103,765	4.0	14,669	23,335	59.1
Louisiana	1975	500	86,448	100,000	15.7	20,291	37,280	83.7
Maryland	1986	605	99,747	180,000	80.5	24,193	34,771	43.7
Massachusetts	1997	500	132,996	250,000	88.0	N/A	30,246	N/A
Michigan	1993	624	79,798	77,000	-3.5	65,946	68,225	3.5
Missouri	1988	547	106,397	162,500	52.7	25,999	38,759	49.1
Montana	1997	250	39,899	100,000	150.6	18,697	27,011	44.5
New Mexico	1996	600	132,996	110,000	-17.3	N/A	67,161	N/A
North Dakota	1996	500	76,473	75,000	-1.9	N/A	16,238	N/A
Utah	1996	250	26,599	115,000	332.3	20,474	37,290	82.1
Virginia	1992	1,000	66,498	200,000	200.8	16,497	21,343	29.4
West Virginia	1986	1,000	132,996	140,465	5.6	N/A	56,989	N/A
Wisconsin	1995	350	119,697	256,357	114.2	18,111	17,213	-5.0
Total			79,798	110,000	37.8	20,414	30,246	48.2

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

Appendix 2

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

State	1991 Median Payout ($)	2002 Median Payout ($)	% Change 1991 to 2002	1991 Median Premium ($)	2002 Median Premium ($)	% Change 1991 to 2002
Alabama	99,747	200,000	100.5	25,629	23,490	-8.3
Arizona	88,941	169,240	90.3	37,601	38,571	2.6
Arkansas	96,416	125,000	29.6	10,422	16,384	57.2
Connecticut	88,659	250,000	182.0	29,198	40,146	37.5
Delaware	97,804	150,000	53.4	N/A	24,731	N/A
District of Columbia	228,754	162,500	-29.0	28,085	40,871	45.5
Florida	126,347	162,500	28.6	43,600	95,474	119.0
Georgia	99,747	175,000	75.4	27,998	30,093	7.5
Illinois	152,946	320,000	109.2	39,260	49,948	27.2
Iowa	54,861	102,500	86.8	21,140	18,607	-12.0
Kentucky	64,181	49,000	-23.7	23,666	44,834	89.4
Maine	99,747	250,000	150.6	22,118	18,583	-16.0
Minnesota	59,848	125,000	108.9	8,117	10,142	25.0
Mississippi	59,848	131,500	119.7	19,726	30,871	56.5
Nebraska	46,549	131,250	182.0	N/A	14,710	N/A
Nevada	43,224	175,000	304.9	24,988	59,776	139.2
New Hampshire	66,498	250,000	276.0	N/A	27,157	N/A
New Jersey	99,747	210,000	110.5	20,162	38,307	90.0
New York	99,747	200,000	100.5	48,026	50,970	6.1
North Carolina	95,757	195,000	103.6	11,294	31,687	180.6
Ohio	32,806	137,500	319.1	31,450	52,764	67.8
Oklahoma	66,498	97,000	45.9	9,137	12,766	39.7
Oregon	86,448	95,000	9.9	17,268	26,711	54.7
Pennsylvania	132,996	200,000	50.4	11,433	71,260	523.3
Rhode Island	83,123	125,000	50.4	N/A	27,922	N/A
South Carolina	79,100	100,000	26.4	12,984	21,337	64.3
South Dakota	33,249	150,000	351.1	9,618	13,853	44.0
Tennessee	78,135	110,000	40.8	15,601	30,018	92.4
Texas	93,559	150,000	60.3	27,945	55,951	100.2
Vermont	56,523	40,865	-27.7	N/A	15,690	N/A
Washington	53,199	150,000	182.0	18,158	23,100	27.2
Wyoming	106,397	125,000	17.5	22,758	39,829	75.0
Total	87,553	150,000	71.3	22,118	30,056	35.9

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

Appendix 3

Weakest Medical Malpractice Insurers

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

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

Source: Weiss Ratings, Inc.

Appendix 4

Other Studies and Position Statements published by Participants in this Debate

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

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

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

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

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

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

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

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

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

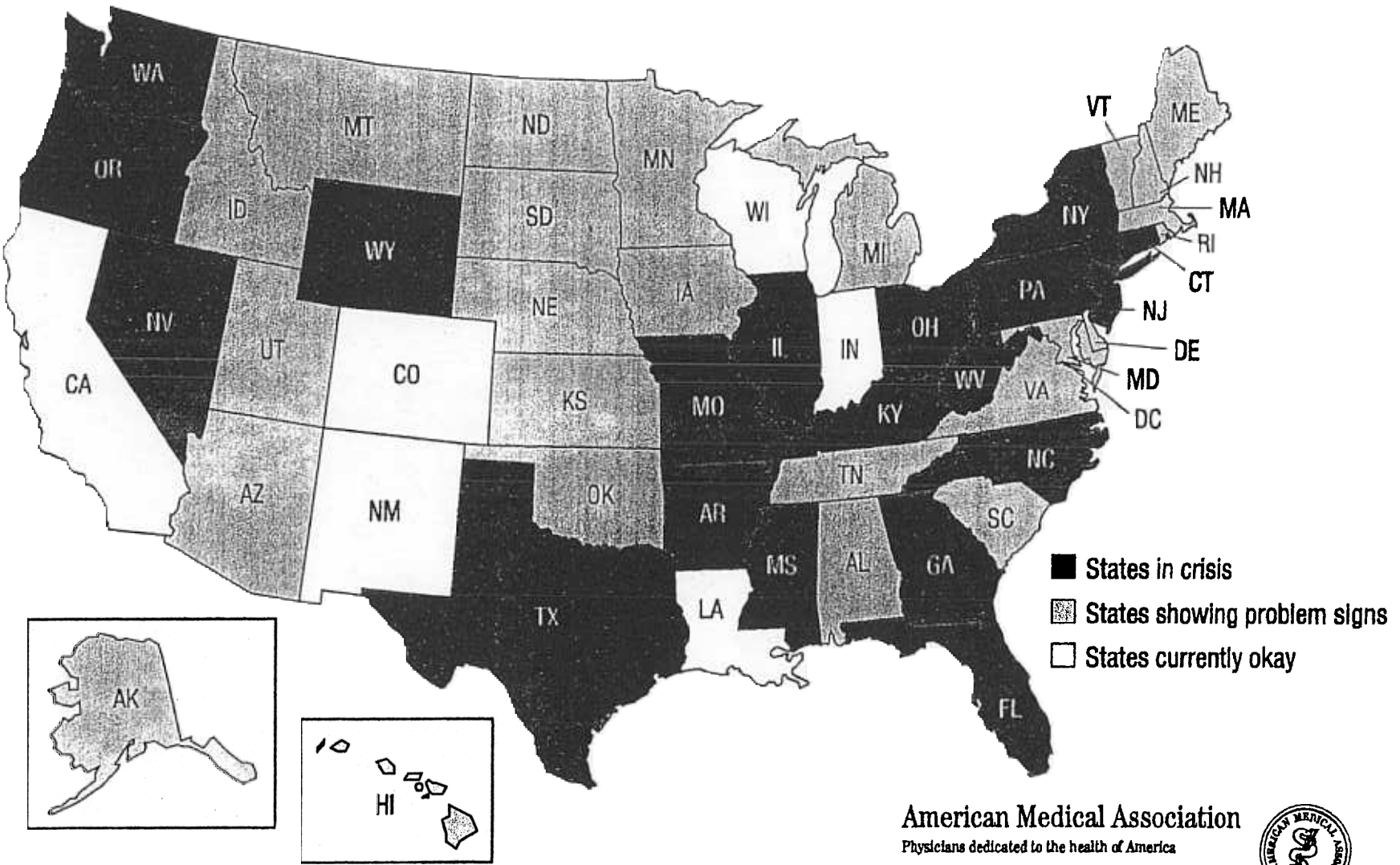
Wyoming Jury Verdicts
Medical Malpractice Cases
1989-2001

$0	26	84%
$1-9,999	0	0%
$10,000-24999	0	0%
$25,000-49,999	0	0%
$50,000-74,999	0	0%
$75,000-99,999	2	6.5%
$100,000-249,999	0	0%
$250,000-499,999	2	6.5%
$500,000-749,999	0	0%
$750,000-999,999	1	3%
$1 Million or more	0	0%
TOTAL	31	100%

COMMENTS:

These figures include final jury verdicts in the courts which are not presently on appeal. Information for 1986-1996 was gathered by the Wyoming Trial Lawyers Association through contact with the clerks of court in each district and updated using Wyoming Jury Verdict Reports. Information for 1997 through 2000 was collected and provided by Jury Verdict Reports with cooperation from the Courts, the University of Wyoming College of Law and the Plaintiff's and Defense bars. Percentages may change as more complete information becomes available. Only personal injury cases are represented and don't include insurance bad faith, contract, civil rights and employment cases

America's Medical Liability Crisis: A National View



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