

# **MEDICAL MALPRACTICE INSURANCE COSTS AND COVERAGE**

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**Prepared by  
GREATER NEW YORK HOSPITAL ASSOCIATION**

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**January 2005**

## Executive Summary

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Medical malpractice insurance premium costs and experience have, according to many sources, reached crisis proportions, with impacts ranging from depressed provider finances to limits on patients' access to care. In order to understand more fully the nature of current malpractice issues and their impact on cost and coverage, GNYHA reviewed the available literature on the subject and, in the interest of adding to the body of knowledge about hospitals' malpractice experience in New York, conducted surveys of member hospitals' premium and coverage experience from the period 1999–2004. This report summarizes the major findings in the literature as well as the findings of GNYHA's survey.

The report covers several aspects of the accessibility and affordability of provider malpractice coverage. It describes the challenges faced by hospitals (Section I), physicians (Section II), and long term care providers (Section III) in accessing malpractice coverage. It examines the financial condition of malpractice carriers (Section IV) and evaluates the evidence of effects on patients' access to services (Section V). Sections VI and VII review factors contributing to premium increases and the connection between malpractice and negligence. The report concludes by reviewing the major types of malpractice reforms undertaken by various states and study findings as to their relative effectiveness (Section VIII).

The major findings of this report are as follows:

- Nationally, hospital and physician malpractice costs have increased dramatically since the 1990s. As noted by the National Association of Insurance Commissioners (NAIC) in a draft medical malpractice report, the health care profession is struggling with a medical liability crisis of decreasing availability of coverage and increasing cost.
- GNYHA's survey showed that hospitals in the downstate New York area have experienced average annual malpractice premium increases of 27% per year from 1999 through 2004 (compound annual growth rate of 17%). The cumulative percentage increase in malpractice premiums was 147%. Increased malpractice premiums were, furthermore, not accompanied by increased coverage; conversely, no hospitals reported an increase in per claim primary coverage limits during this period of escalating premium growth.
- New York is one of 20 medical malpractice "crisis states" for physicians designated by the American Medical Association (AMA). New York's various attempts to ensure the availability and affordability of physician malpractice coverage include granting authority to the State Insurance Department (SID) Superintendent to set premium increases each year, creating a special program to insure providers who cannot obtain coverage through mainstream carriers, and establishing a taxpayer-funded pool to provide an extra layer of physician malpractice coverage. Despite these efforts, New York's physician premiums are among the very highest in the nation and the number of providers relying upon the high-risk pool program is growing.

- From 1992 to 2003, long term care nursing facilities experienced a sevenfold increase in costs per bed related to defending malpractice claims. Suits against nursing homes are among the fastest growing areas of health care litigation, and liability costs are occupying a greater and greater proportion of available Medicaid reimbursement, the primary source of payment for nursing home care.
- Contributing to providers' limited access to coverage is the fact that a number of malpractice carriers have exited the market in recent years. In the past four years, two of the six insurance companies offering physician coverage in New York have become insolvent and two more have stopped offering specific lines of coverage. According to the NAIC, based on 2002 data, New York's insurers have the fourth worst loss experience of any state in the country, paying out on average \$1.44 in claims and expenses for every \$1.00 collected in premiums. Only Illinois, Nevada, and Mississippi have worse loss ratios. If carriers increased their premiums to achieve better financial performance, however, it would only worsen the malpractice crisis by making coverage more unaffordable.
- Increasing costs per malpractice claim—as opposed to an increasing number of claims being filed—constitutes the single largest driver of increases in malpractice premiums. Six out of the top 10 malpractice verdicts reported in the country in 2002 occurred in the metropolitan New York area, with five in New York City alone. Awards may typically be appealed or settled, and the relevance of mega-awards, or the well-founded fear of them, is that they drive higher settlements.
- The malpractice crisis appears to be affecting patients' access to services as obstetrician/gynecologists (OB/GYNs) report that they have stopped or decreased the amount or nature of obstetrical care they perform because they fear malpractice exposure. In New York, the number of OB/GYNs per 100,000 population caring for patients decreased by 4.1% from 1998 to 2002, while the number of patient care physicians per 100,000 overall declined by 1.5%.
- Available studies show little correlation between actual provider negligence on the one hand and malpractice claims and awards on the other. That is, few negligent injuries result in malpractice claims, and few malpractice claims actually involve negligence. One study found that the severity of a plaintiff's disability is a more reliable predictor of the size of a jury award than the existence of actual negligence.
- States have adopted a variety of reforms intended to address the amount and frequency of malpractice awards. These reforms include caps on non-economic damages such as pain and suffering; caps on punitive damages; allowing juries to consider evidence of other sources of monetary payments to plaintiffs, such as health insurance or workers compensation, when awarding damages; limits on joint and several liability; periodic payments over time of malpractice awards; and caps on attorneys' fees. Of those reforms, the literature suggests that caps on damages bear the most direct relationship to reduced malpractice costs.

## I. Escalating Hospital Premiums

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Hospitals and physicians in many states have experienced dramatic increases in medical malpractice premiums since the late 1990s. According to the United States Congressional Joint Economic Committee, malpractice premiums have increased, on average, by 8.1% per year from 1992 to 2001—a rate that is three times higher than the overall rate of inflation for that period and double the rate of medical inflation.<sup>1</sup> The United States Department of Health and Human Services (HHS), in a March 2003 report, and the Congressional Budget Office (CBO), in a 2004 issue brief, similarly report sharp increases in medical malpractice premiums over the past few years.<sup>2,3</sup> These studies are cited throughout this report as the 2003 HHS Study and the CBO Issue Brief, respectively.

### Hospital Premiums

Nationally, hospital premiums are increasing precipitously (see figure 1). An American Hospital Association/Lewin Group survey showed that in 2001, over 82% of hospitals responding to the survey experienced premium increases of more than 10%, with 28% of respondents experiencing premium increases of more than 50%. The data from 2002 suggest that the crisis is worsening, with 85% of hospitals experiencing premium increases of more than 10%, and 44% of hospitals suffering premium increases exceeding 50%.<sup>4</sup>

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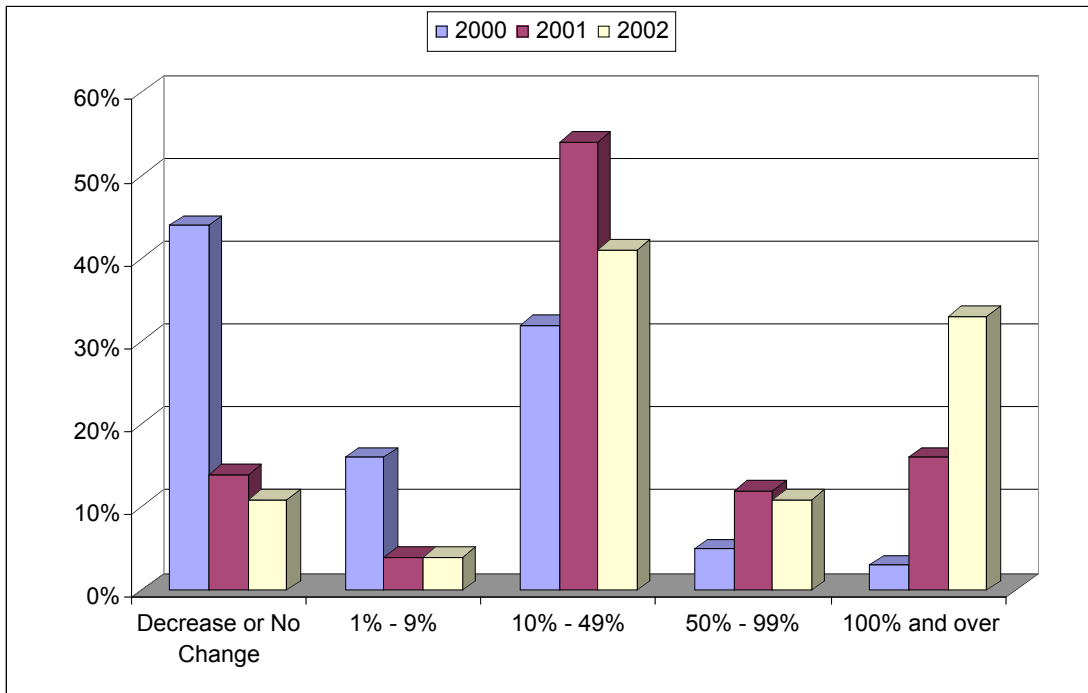
<sup>1</sup> Joint Economic Committee, United States Congress, *Liability for Medical Malpractice: Issues and Evidence* (Washington, D.C., May 2003), p. 4.

<sup>2</sup> U.S. Department of Health and Human Services, *Addressing the New Health Care Crisis: Reforming the Medical Litigation System to Improve the Quality of Health Care* (Washington, D.C., March 2003), p. 1.

<sup>3</sup> Congressional Budget Office, *Limiting Tort Liability for Medical Malpractice* (Washington, D.C., January 8, 2004), p. 1.

<sup>4</sup> American Hospital Association and The Lewin Group, “Medical Liability Insurance: Looming Crisis?” *Trend Watch* 4, no. 3 (June 2002): 1.

**Figure 1: Percentage Change in Nationwide Hospital Premiums—2000, 2001, 2002**



Source: American Hospital Association and The Lewin Group, “Medical Liability Insurance: Looming Crisis?” *Trend Watch* 4, no. 3 (June 2002): 1.

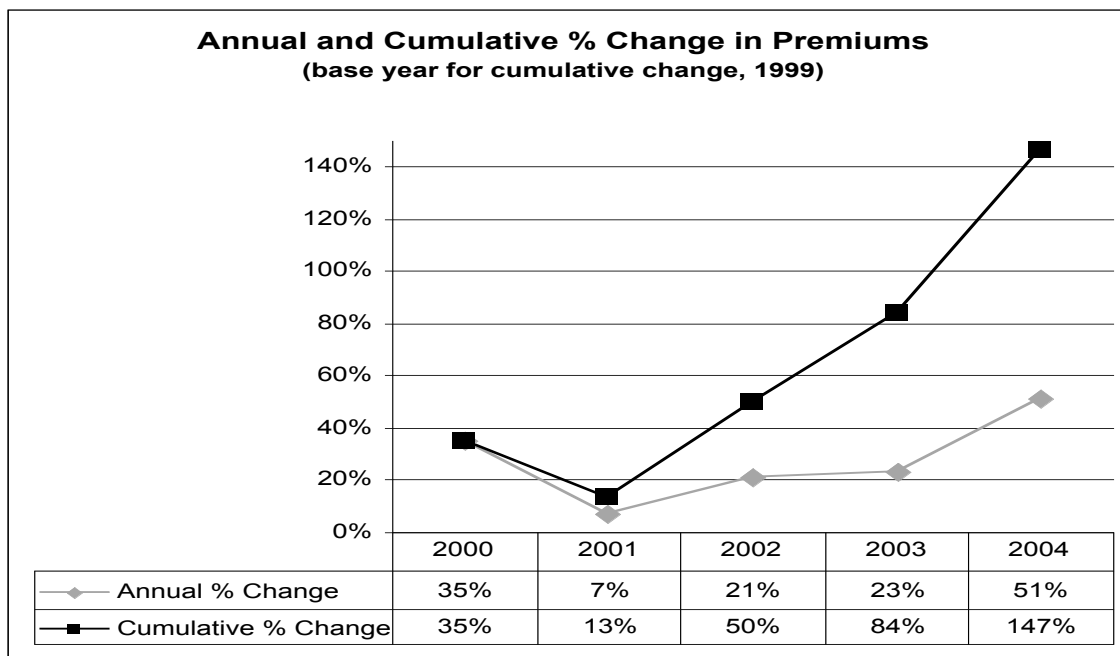
To understand the scope and nature of hospitals’ malpractice experience in New York, GNYHA conducted a survey of its members’ malpractice premium and coverage experience during the period 1999–2004. Survey response data were augmented with telephonic interviews conducted by GNYHA. The survey results indicate that hospital malpractice premiums have increased substantially over the 1999–2004 period.

Forty out of 84 hospitals responded to the survey, representing 48% of the institutions and 60% of the total operating expenses of the potential sample. For purposes of analysis, only those hospitals that reported data in every year were included.<sup>5</sup> These respondents represented 36% of the total operating expenses of all hospitals in New York State. Respondents’ hospital malpractice premiums increased an average of 27% (17% compounded annually) per year and 147% cumulatively over the 1999–2004 period.<sup>6</sup> Several hospitals experienced premium increases in the 40% range in one or more years, and one hospital recorded a one-year premium increase of 152%. The premium increases (and decreases in very few cases) have varied substantially from year to year, but they show a generally sizable upward trend (see figure 2). These increases reflect the aggregate costs of primary and secondary coverage where applicable.

<sup>5</sup> N=34, 40% of hospitals surveyed, 53% of the operating expenses of the potential sample.

<sup>6</sup> Hospital premium data are unweighted—i.e., each hospital is counted as one data point and the average reflects all hospitals, with each hospital weighted equally.

**Figure 2: Annual and Cumulative Percent Change in Premiums—Sample NY Hospitals**



Source: GNYHA 2004 Medical Malpractice Survey. Note: Hospitals with self-funded plans may over-reserve in one year and then take money out the following year as a correction. One of the hospital respondents experienced a large correction in the 2000-2001 period.

If the study hospitals’ malpractice costs expressed as a percentage of operating expenses were extrapolated to all hospitals in New York State, hospital malpractice premium costs would approach \$1 billion annually.<sup>7</sup>

The New Jersey Hospital Association conducted a medical malpractice survey in 2003, which suggests that hospital premiums have increased even more dramatically in New Jersey, with an average increase of 71% from 2002 to 2003 and a cumulative increase of 378% since 1999.<sup>8</sup>

### **Changes in Policy Coverage Limits—1999 versus 2004**

The GNYHA survey results indicate that, despite increases in premiums, in most cases policy coverage limits are staying the same or decreasing. In other words, many hospitals are paying more for the same or less coverage.

Malpractice policies generally have limits on a per claim basis (that is, the maximum dollars that may be paid for a single claim), as well as on an aggregate basis (that is, the total dollars that may be paid out in a policy year regardless of the number of claims). In

<sup>7</sup> Extrapolation is based on premium as a percent of operating expenses in 2002 extrapolated to all New York hospitals using 2002 New York State Institutional Cost Report data.

<sup>8</sup> New Jersey Hospital Association, *Medical Malpractice Insurance Survey* (Princeton, September 2003).

addition, many hospitals purchase at least two layers of malpractice insurance—a primary layer, which covers losses up to a prescribed limit (after all deductibles and cost-sharing requirements are met), and a secondary layer, which pays once the primary layer has been exhausted.<sup>9</sup>

As indicated in table 1, more than half of the study hospitals (58%) experienced a decrease in per claim limits on their primary policy and fewer than half (42%) maintained the same coverage from 1999 to 2004. Significantly, no hospitals increased their primary per claim coverage over this time period. In 42% of the cases, aggregate coverage did increase for the primary layer, but in some cases this increase may reflect a shift from secondary coverage to primary coverage, because the aggregate limit for the secondary coverage decreased in 63% of the cases.<sup>10</sup> These decreases in aggregate coverage suggest that, despite the large premium increases, many hospitals accepted greater financial risk over this time period. In one hospital, secondary aggregate limits decreased by 51% over the 1999–2004 period, with a corresponding 210% increase in premium. This case is an extreme example of the general trend that occurred at other responding hospitals on a lesser scale.

**Table 1: Percentage of Hospitals with Changes in Policy Coverage 1999 versus 2004**

Coverage Experience 1999–2004	Primary Layer		Secondary Layer	
	Per Claim	Aggregate	Per Claim	Aggregate
Decrease in Coverage	58%	42%	20%	63%
Same Coverage	42%	16%	60%	16%
Increase in Coverage	0%	42%	20%	21%

Source: GNYHA 2004 Medical Malpractice Survey.

### Changes in Premium Costs versus Reimbursement

GNYHA compared the rate of change in the study hospitals’ medical malpractice costs with annual increases in the medical malpractice portion of the Medicare payment update factor—the hospital market basket—which is intended to account for increases in the hospital input prices. Medicare’s annual increases are grossly inadequate to cover the

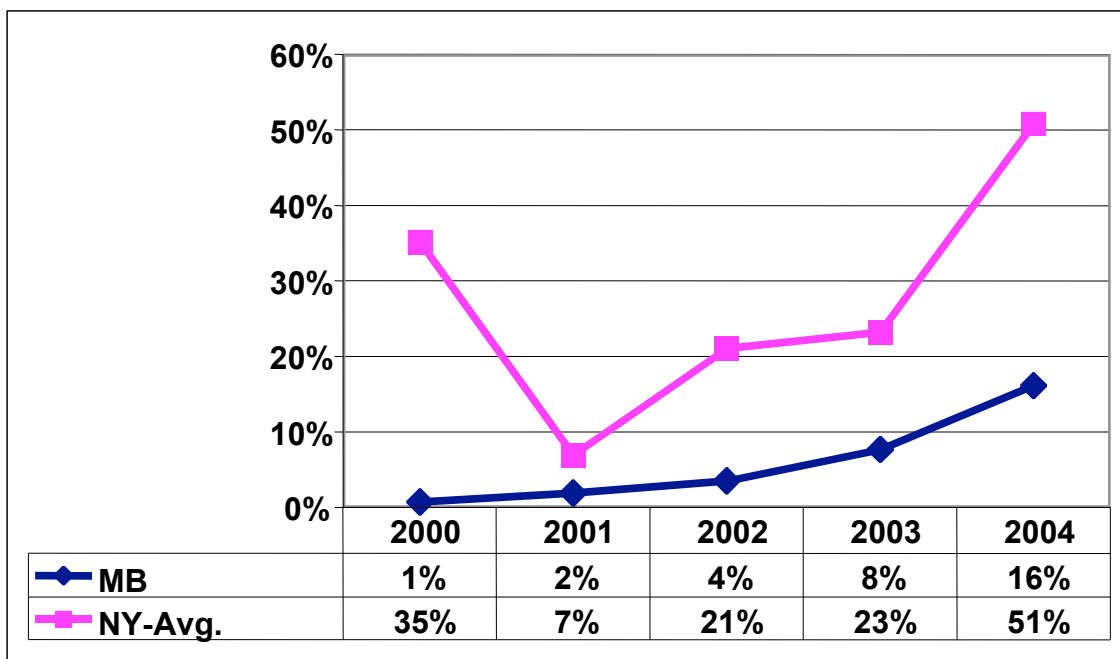
<sup>9</sup> For example, a hospital may have primary insurance with a coverage limit of \$10 million per claim and secondary insurance with a coverage limit of \$25 million per claim. If a claim were made against the hospital for \$20 million, the primary insurer would pay \$10 million and the secondary insurer would cover the remaining \$10 million.

<sup>10</sup> Secondary coverage attaches when the first layer of coverage is exhausted. For example, if the hospital has primary per claim coverage of \$10 million and secondary coverage of \$25 million, and a claim were made for \$20 million, the primary would pay the first \$10 million and the secondary would pay an additional \$10 million. However, if the primary per claim limit increased to \$15 million but the secondary limit continued at \$25 million, then the primary would pay the first \$15 million and the secondary would pay the additional \$5 million.

growth in malpractice insurance expenses in New York for two reasons: malpractice costs in New York have grown more rapidly than Medicare’s malpractice component and malpractice costs represent a greater share of New York hospitals’ total operating expenses than is reflected in the market basket.

Figure 3 illustrates the growth in medical malpractice insurance expenses in New York versus the growth of the malpractice component of the Medicare hospital market basket. On average, from 2002 through 2004, the growth rate of New York’s malpractice insurance expenses exceeded the growth rate of the Medicare hospital market basket proxy by a factor of four.<sup>11</sup>

**Figure 3: Annual Growth in Medical Malpractice Insurance Expenses—New York Hospitals versus Medicare Hospital Market Basket (MB) Proxy**

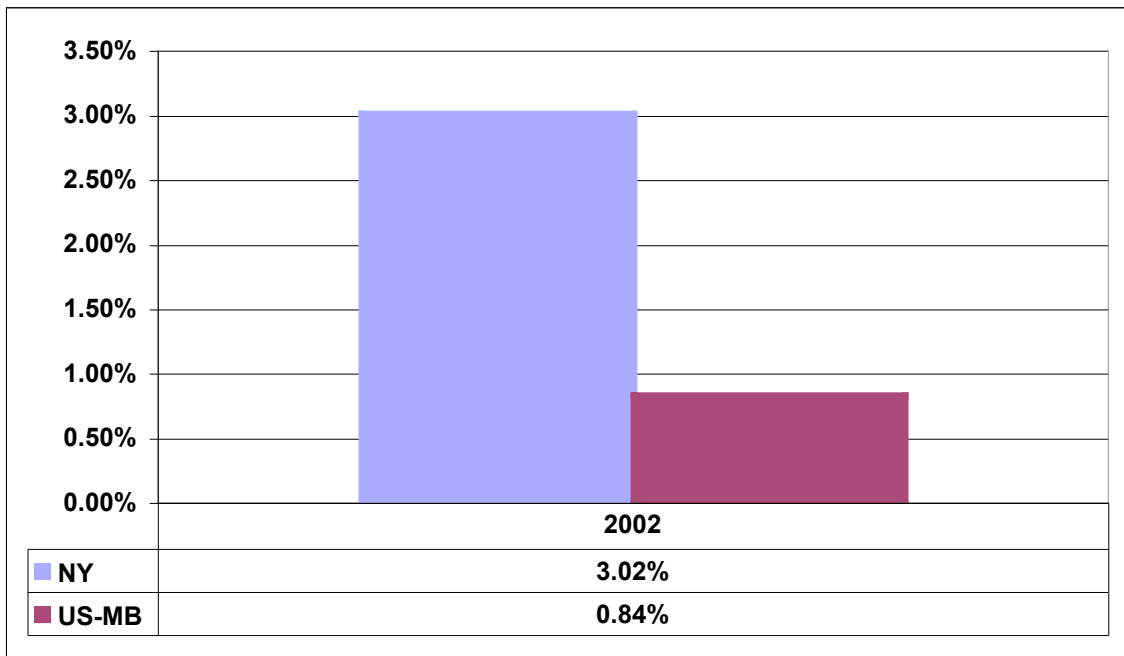


As shown in figure 4, medical malpractice expenses represent a greater share of total operating expenses in New York than in the hospital market basket.<sup>12</sup> From 1999 through 2002, medical malpractice insurance expenses represented 3% of total operating expenses in New York, while the medical malpractice proxy in the U.S. hospital market basket carried a weighting of only 0.84%.

<sup>11</sup> The medical malpractice insurance proxy in the hospital market basket is the CMS Professional Liability Insurance Premiums Index.

<sup>12</sup> The hospital market basket excludes capital-related costs; therefore, New York’s total operating expenses in this computation also exclude capital-related costs.

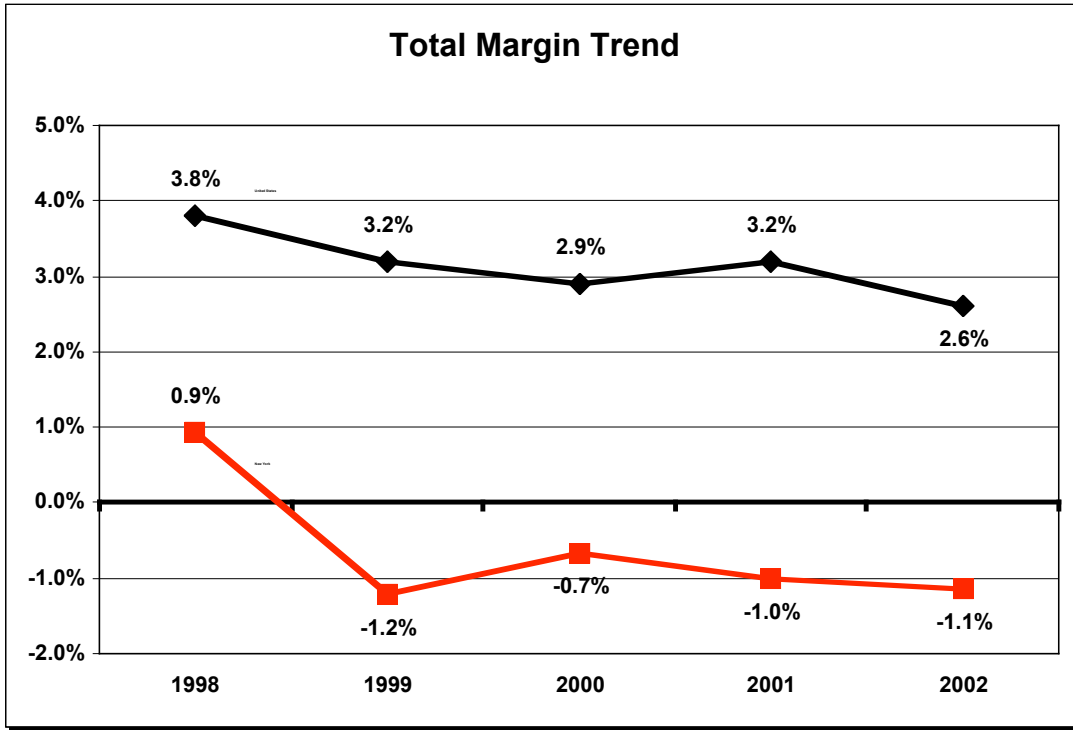
**Figure 4: Medical Malpractice Insurance Expense as a Percent of Total Operating Expenses—New York Versus the Medicare Hospital Market Basket**



As a result of these disparities, Medicare fails to reimburse New York hospitals adequately for the malpractice portion of their costs. In addition, malpractice premium costs are not considered as part of the Medicaid trend factor, which is based on the consumer price index.

The context for the disproportionate increases in hospital malpractice costs in New York is that the State’s hospitals also suffer from among the worst financial conditions of hospitals anywhere in the country. In every year from 1998 through 2002, hospitals in New York suffered bottom-line losses (see figure 5). In addition, New York hospitals ranked among the lowest of hospitals anywhere in the country on other standard measures of financial condition (see table 2).

**Figure 5: New York Hospitals Have Had Four Straight Years of Bottom-Line Losses**



Sources: For U.S. data, the *Almanac of Hospital Financial and Operating Indicators, 2004* (Salt Lake City: Ingenix, 2003). For New York data, the 2002 New York State Institutional Cost Reports (ICRs).

**Table 2: The Financial Condition of New York Hospitals is Among the Worst in the United States**

	U.S.	New York	NY Rank
<b>Profitability</b>			
Total Margin	2.6%	-1.1%	2d lowest
<b>Liquidity</b>			
Current ratio	2.00	1.30	3d lowest
Days in average payment period	55	77	2d lowest
<b>Capital structure</b>			
Equity financing ratio	55%	32%	2d lowest
Debt service coverage ratio	2.9	1.7	3d lowest

Source: *Almanac of Hospital Financial and Operating Indicators, 2004* (Salt Lake City: Ingenix, 2003).

## **Hospital Survey Data**

Survey data are particularly valuable in the context of hospital malpractice costs because of the prevalence of self-insurance arrangements. In response to malpractice crises in the mid-1970s and 1980s, and the resulting difficulty in obtaining affordable insurance, hospitals began to explore alternatives to traditional commercial insurers. The result was that an increasing number of hospitals opted to self-insure, on their own or through the formation of captive insurance companies (“captives”), which are in turn owned by the hospitals that receive coverage. The purpose of these captives is to ensure stable coverage for their owners, rather than to maximize profits.<sup>13</sup> These alternative structures now represent a large part of the market. Of the 40 hospitals responding to the GNYHA survey, 43% were self-insured versus 57% that purchased commercial coverage.

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<sup>13</sup> Joint Economic Committee, United States Congress, *Liability for Medical Malpractice: Issues and Evidence* (Washington, D.C., May 2003), p. 5.

## II. Physicians Face High Costs

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The Government Accountability Office conducted an in-depth analysis of physician malpractice premium experience in seven states and published a report in 2003 (the “GAO Premium Report”), which concluded that premiums increased dramatically in a number of these states.<sup>14</sup> According to the CBO Issue Brief, physician premiums increased nationally by 15% from 2000 to 2002, or at nearly twice the rate of health care spending per person.<sup>15</sup> The increases have been more dramatic for some specialties, such as internal medicine and general surgery, which increased by 20% and 21.9%, respectively, during the 1999–2002 period (see table 3).

**Table 3: Percent Change in Nationwide Malpractice Premiums by Physician Specialty, 1999–2002**

Year	OB-GYN	Internal Medicine	General Surgery
1999	2.1%	5.1%	1.1%
2000	4.8%	7.3%	7.0%
2001	10.3%	9.9%	12.0%
2002	14.2%	20.0%	21.9%

Source: Medical Liability Monitor data analyzed in K. Thorpe, “The Medical Malpractice ‘Crisis’: Recent Trends and the Impact of State Tort Reforms,” *Health Affairs* (January 21, 2004): W4-21.

New York is one of 20 medical malpractice crisis states as defined by the American Medical Association (AMA). The AMA defines crisis states as areas of the country where physicians are retiring early, relocating, or changing their practice—for example, by no longer performing high-risk medical procedures. Figure 6 depicts states in crisis.

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<sup>14</sup> GAO, *Medical Malpractice Insurance: Multiple Factors Have Contributed to Increased Premium Rates*, GAO-03-702 (Washington, D.C., June 2003), p. 10.

<sup>15</sup> CBO, *Limiting Tort Liability*, p. 1.



and recommended by malpractice carriers. For example, for the July 2004–July 2005 premium year, SID approved an average increase of 7.0% for most physicians while some insurers had requested rate increases as high as 25.7%.<sup>17</sup> The average physician premium rate increases for commercial carriers, as well as for those hard-to-insure physicians covered by the MMIP, are shown in table 4.

The 2004–2005 premium year atypically subjected all specialties and territories to a uniform 7% increase. However, these average commercial premium rate changes mask much larger increases for certain specialties and territories. In the 2003–2004 premium year, for example, the average increase was 8.5% but there was considerable variation by specialty and territory. Emergency physicians and general surgeons in the Bronx, Kings, Queens, and Richmond counties experienced premium increases of 18.3%, while pediatricians in Erie and Niagara counties saw a 3.2% decrease in their premiums.

Table 4 also does not reflect the increased costs for physicians participating in New York’s excess malpractice insurance program. These doctors must pay an additional 6% due to a new statutory requirement that increased minimum primary policy limits from \$1 million per claim, \$3 million aggregate, to \$1.3 million per claim \$3.9 million aggregate (amendment to §18 of Chapter 266 of the Laws of 1986).

**Table 4: Average Physician Medical Malpractice Rate Increases, New York State**

<b>Year</b>	<b>Commercial Rate Change</b>	<b>MMIP Rate Change<sup>a</sup></b>
1999–2000	0.0%	20%
2000–2001	1.8%	25%
2001–2002	0.8%	20%
2002–2003	1.0%	20%
2003–2004	8.5%	30%
2004–2005	7.0%	20%

Note: Increases apply to policy years beginning July 1.

<sup>a</sup>Medical Malpractice Insurance Plan.

Physician malpractice premiums and rate increases in the commercial market are set by specialty and territory. Premium amounts and annual increases vary by territory and specialty class (see table 5) but physicians within a class in a given territory generally pay the same premium with some exceptions—a surcharge may be applied based on prior claims history or disciplinary actions and physicians may receive a credit for completing a prescribed risk-management program.

Table 5 illustrates premiums for specific specialties for those physicians purchasing insurance in the voluntary commercial market. Coverage is for \$1 million per claim, \$3 million aggregate.

<sup>17</sup>“Superintendent Serio Announces Continued Stabilization of Medical Malpractice Rates for New York’s Physicians,” New York State Insurance Department press release, 1 July 2004. Accessed via Web site, [www.ins.state.ny.us/p0407011.htm](http://www.ins.state.ny.us/p0407011.htm).

**Table 5: Physician Medical Malpractice Premiums by Specialty and Geographic Region for \$1 Million per Incident, \$3 Million Aggregate Coverage, 2004–05**

Territory	Specialty Class <sup>a</sup>		
	Neurosurgery	Obstetrics/ Gynecology	Internal Medicine <sup>b</sup>
<b>1</b> New York, Orange, Rockland, Sullivan, Westchester	\$160,213	\$97,663	\$18,316
<b>2</b> Bronx, Kings, Queens, Richmond	\$190,042	\$115,847	\$21,726
<b>3</b> Nassau, Suffolk	\$207,050	\$126,214	\$23,671
<b>4</b> Columbia, Dutchess, Greene, Putnam, Ulster	\$98,347	\$59,951	\$11,243
<b>5</b> Erie, Niagara	\$61,810	\$37,678	\$7,066
<b>6</b> Livingston, Monroe, Ontario, Seneca, Wayne, Yates	\$43,514	\$26,526	\$4,975
<b>0</b> All other counties	\$58,366	\$35,579	\$6,673

Note: Physicians must purchase an additional \$300,000 per incident, \$900,000 in aggregate to participate in the excess pool, which is described in greater detail below. The cost of this additional coverage is 6% of the premium shown in this table.

<sup>a</sup>Premiums reflect occurrence policy rates.

<sup>b</sup>Premium Class 13.

### **Ensuring Availability of Insurance for Physicians through a Joint Underwriting Arrangement—Medical Malpractice Insurance Plan**

In the mid-1970s, a medical malpractice insurance crisis was precipitated by the departure from the underwriting market of two large insurers at the time, Employers Insurance Company of Wausau and the Professional Insurance Company of New York. In response, the Medical Malpractice Insurance Association (MMIA) was created by an act of the Legislature in 1975 and served as a joint underwriting association that provided insurance to doctors and hospitals that could not purchase insurance in the commercial market. MMIA was dissolved in 2001 and replaced with the Medical Malpractice Insurance Plan (MMIP), which provides malpractice insurance to providers otherwise unable to obtain coverage.

The MMIP is administered by the Medical Liability Mutual Insurance Company (MLMIC) but is funded by all malpractice insurers on a pro rata basis based on their shares of the medical malpractice market. As was seen in table 4, above, overall premium increases for

MMIP have been much larger than those for the commercial insurers. As shown in table 6, below, the 2004 premium for OB/GYNs participating in MMIP is substantially higher than the premium available in the commercial market.

**Table 6: MMIP versus Commercial Market OB/GYN Premiums: 2004**

<b>Counties</b>	<b>Commercial OB/GYN Premium</b>	<b>MMIP OB/GYN Premium</b>
New York, Orange, Rockland, Sullivan, Westchester	\$97,663	\$266,061
Bronx, Kings, Queens, Richmond	\$115,847	\$315,587
Nassau, Suffolk	\$126,214	\$343,849

The number of providers participating in MMIP increased dramatically for the excess layers of insurance between 2001 and 2003 (see table 7). This increase is attributable in part to insurers exiting the market. The other commercial carriers may not offer policies to physicians and other providers losing coverage, depending on their risk profile.

**Table 7: Number of Providers Insured through the Medical Malpractice Insurance Plan**

<b>Layer</b>	<b>Number of Policies</b>		
	<b>12/31/01</b>	<b>12/31/02</b>	<b>12/31/03</b>
<b>Primary Layer</b>	787	819	845
<b>First Layer Excess</b>	151	292	1,701
<b>Second Layer Excess</b>	165	1,295	1,569

Note: Providers reflected in this table include physicians, dentists, podiatrist, nurse anesthetists, nurse midwives, and professional corporations.

Source: *Annual Report of the Superintendent of Insurance to the New York Legislature*, Calendar Year 2003.

As discussed in greater detail in Section IV, the MMIP has a deficit of more than \$233 million,<sup>18</sup> which must be borne by medical malpractice insurers in New York and is contributing to their poor financial performance.

### **Physician Excess Liability Program**

In 1985, after several years of double-digit premium increases and physician concerns that coverage was insufficient, the State established the physician excess liability program, which provides an additional \$1 million per claim and \$3 million aggregate layer of malpractice coverage for qualifying physicians. The excess malpractice insurance program

<sup>18</sup> Based on conversations with Medical Liability Mutual Insurance Company, which administers the MMIP program. Deficit based on June 30, 2004 un-audited financial statement.

is funded through the Health Care Reform Act (HCRA), which in turn is funded by a variety of assessments on hospitals and payers as well as revenues from other programs. In order to participate in the excess liability program, a physician must meet three criteria:

1. Purchase a primary policy of \$1.3 million per claim and \$3.9 million aggregate.<sup>19</sup>
2. Participate in a proactive risk-management program.
3. Have hospital privileges.

**Table 8: Physician Insurance Coverage Limits (millions of \$)—Excess Liability Program**

	<b>Primary Layer—Purchased by Physician</b>	<b>Excess—Provided Through Program</b>	<b>Total Coverage</b>
Per Claim	\$1.3	\$1	\$2.3
Aggregate	\$3.9	\$3	\$6.9

Approximately 26,000 physicians participate in the excess liability program.

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<sup>19</sup> As noted earlier, the Insurance Superintendent regulates premium increases for primary policies of \$1 million per claim/\$3 million aggregate. Therefore, physicians who wish to participate in the excess program must have additional coverage to reach the \$1.3 million/\$3.9 million minimums. This additional coverage is also regulated by SID and costs 6% of the basic coverage cost reflected in table 5.

### III. Long Term Care Liability Insurance Issues

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Insurance carriers who offer medical malpractice insurance are also affected by the long term care liability insurance experience, which has been in a crisis mode for the past several years. Long term care liability insurance, which primarily includes professional and general liability insurance, covers circumstances analogous to activities covered under hospital medical malpractice insurance. For example, long term care liability insurance covers claims related to patient care issues. For patient care cases, nursing facilities might also invoke supplemental insurance, which covers excess claims of professional and general liability. In addition, nursing facilities might invoke director's and officer's insurance when the Administrator and/or members of the Board of Directors are named in a cause of action against the facility.

On a national level, the Federal government has recognized the long term care liability crisis and the litigation costs related to this crisis. In a hearing before the Senate Special Committee on Aging on July 15, 2004, AON Risk Consultants, Inc. demonstrated that nursing facilities nationwide have experienced a sevenfold increase in costs per bed related to defending alleged claims from 1992 to 2003.<sup>20</sup> Long term care providers are largely funded by Medicaid, which limits reimbursement rate increases to levels that do not cover the increasing cost of long term care liability insurance. Therefore, long term care liability costs as a percent of the average reimbursement rate nationwide increased from 2% in 1995 to 5% in 2003.<sup>21</sup> Researchers at the Harvard School of Public Health confirmed that suits against nursing facilities are among the fastest growing areas of health care litigation and demonstrated a significant increase in the number of nursing home claims attorneys have handled and the average size of recoveries in the past five years.<sup>22</sup>

In New York State, long term care facilities are unable to find liability insurance coverage in the commercial market and therefore have sought coverage from the Medical Malpractice Insurance Plan (MMIP) of New York State, the last resort liability insurance carrier for health care providers. In the State Insurance Department (SID) Annual Report for 2003, SID stated that the number of facilities insured by MMIP increased from 132 in 2002 to 259 in 2003 and that the increase was attributable to nursing homes' and adult care homes' inability to obtain coverage in the voluntary market.<sup>23</sup>

In 2003, an American Medical Directors Association survey found that nearly 35% of physicians working in long term care were refused professional liability insurance because they worked in nursing homes. As a result, 18.4% of these doctors changed their practices, 25% reduced their long-term care patient hours, 28% now refer their complicated cases to

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<sup>20</sup> Testimony of Theresa Bourdon, AON Risk Consultants Inc., Hearing before the U.S. Senate Special Committee on Aging, "Medical Liability in Long Term Care: Is Escalating Litigation a Threat to Quality and Access?" (July 15, 2004).

<sup>21</sup> Ibid.

<sup>22</sup> David Stevenson and Davis Studdart, "The Rise of Nursing Home Litigation: Findings from a National Survey of Attorneys," *Health Affairs* 22, no. 2 (March/April 2003): 219-29.

<sup>23</sup> New York State Insurance Department Annual Report for 2003.

other physicians, and another 10% left long-term care facilities altogether.<sup>24</sup> Medical directors are also leaving the long term care field at an alarming rate, as they have been unable to obtain, or unable to afford, the two kinds of insurance they must carry: one for administrative actions and one for clinical work.<sup>25</sup>

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<sup>24</sup> Testimony of James Lett, American Medical Directors Association, Hearing before the U.S. Senate Special Committee on Aging, "Medical Liability in Long Term Care: Is Escalating Litigation a Threat to Quality and Access?" (July 15, 2004).

<sup>25</sup> *Ibid.*

#### IV. Insurers Fare Poorly, Further Limiting Malpractice Coverage

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Nationally, malpractice insurers today are losing money on every dollar of coverage they write as seen in table 9, which displays data from the Thorpe study. The “loss ratio” column illustrates total malpractice award payouts, settlements, and defense costs as a percentage of premiums. For example, in 2002, insurers paid out \$1.11 in awards and defense costs for every \$1 in premiums. The broad combined ratio measures total insurer expenses, which include malpractice payouts plus insurers’ administrative costs and taxes, as a percentage of premiums. According to this ratio, in 2002, insurers had \$1.29 in expenses for every premium dollar. These data show that despite the large premium increases, insurers have insufficient premium dollars to cover current malpractice losses.

**Table 9: Malpractice Insurers’ Expenditures versus Premium Income**

<b>Year</b>	<b>Loss Ratio (%)</b>	<b>Broad Combined Ratio (%)</b>
1999	91	122
2000	103	129
2001	113	141
2002	111	129

Source: K. Thorpe, “The Medical Malpractice ‘Crisis’: Recent Trends and the Impact of State Tort Reforms,” *Health Affairs* (January 21, 2004).

Regulation of malpractice premiums and the insurance market in states like New York is intended to ensure that all physicians have access to some form of malpractice coverage, albeit at a possibly prohibitively high cost. The cost of insurance, however, still does not tell the whole story, and further, strong evidence of a growing crisis is found in the decreasing number of malpractice carriers willing or able to continue providing this type of insurance. The number of companies writing medical malpractice insurance policies in the United States has decreased dramatically over the last few years, with a reported 14% of malpractice insurers exiting the market and as many as 40% of insurers exiting the market in acute crisis states.<sup>26</sup>

The most striking example of an insurer withdrawing from this market is the St. Paul Companies. St. Paul was once the largest insurer in the nation, writing policies for 9% of all doctors.<sup>27</sup> But the company announced in December of 2001 that it would no longer cover any of the nation’s providers, leaving 42,000 physicians and 750 hospitals without coverage.

Insurers are exiting the market throughout the nation. According to the 2003 HHS Study, 15 insurers left the Mississippi market over the past five years. Only eight companies

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<sup>26</sup> Thorpe, p. 1.

<sup>27</sup> Office of Disability, Aging and Long-Term Care Policy, “Update on the Medical Litigation Crisis: Not the Result of the ‘Insurance Cycle’” (Washington, D.C.: U.S. Department of Health and Human Services, September 25, 2002).

currently write insurance in the Missouri market, down from 32 in 2001. And the number of medical liability insurers in Florida dropped from 66 in the late 1990s to 12 in 2002.<sup>28</sup>

New Jersey was hit particularly hard by the exit of policy writers from its market in 2002. In that year, the State of Pennsylvania declared PHICO—a carrier for 7% of New Jersey’s physicians—insolvent. Then, in May of 2002, the MIIX group, once the single largest insurer of New Jersey physicians, went into voluntary solvent runoff. MIIX Advantage (a smaller spin-off of MIIX) and the Princeton Insurance Company (PIC) filled the gap left by the exit of MIIX and, combined, they now cover more than 75% of the State’s medical malpractice market. But now even PIC is in trouble. In 2002, PIC ended with a \$59 million loss, and in August 2003, PIC had to temporarily suspend writing new policies when it lost its reinsurer.<sup>29</sup>

As described in Section II, despite New York’s laudable efforts to maintain physician access to affordable malpractice coverage, many doctors in the state still face among the highest malpractice premiums in the country. The other side of this story is the effect that these efforts may have had on the regulated carriers and, in turn, on the availability of affordable coverage.

In the past four years, two of the six insurance companies offering physician coverage in New York—Frontier Insurance Company and Group Council Mutual Insurance Company—have become insolvent, with one declaring bankruptcy and the other placed under Insurance Department-supervised financial rehabilitation. Two more—HANYIS Insurance Company (HIC) and Medical Liability Mutual Insurance Company (MLMIC)—have stopped offering specific lines of coverage.

According to SID, only four companies are currently authorized to write medical malpractice insurance for physicians and surgeons. As noted above, two of the four, HIC and MLMIC, dropped their excess physician coverage business effective July 1, 2004 and July 1, 2003 respectively. HIC’s decision to exit the market was based upon its conclusion that the malpractice premium rate increases approved by the State Insurance Department were actuarially insufficient to provide this coverage<sup>30</sup> As a result, as of July 1, the 16,000 physicians previously covered by HIC had to try to obtain coverage from another company in the market. Some portion of them were expected to turn to MMIP, where the increasing number of participants already suggests that it is becoming increasingly difficult to obtain malpractice insurance through the commercial market.

An additional cost for insurers is the Medical Malpractice Insurance Plan (MMIP). All carriers currently writing malpractice insurance in New York participate in the profit and loss of the MMIP. After four years of operation, the MMIP had a cumulative deficit of

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<sup>28</sup> HHS, p. 21.

<sup>29</sup> New Jersey Hospital Association, *Medical Malpractice Insurance Survey* (Princeton, September 2003).

<sup>30</sup> Discussions with HIC, 26 October 2004.

\$233 million as of June 30, 2004, which is up from \$152 million in June 2003.<sup>31</sup> Insurers writing medical malpractice in New York absorb these losses based on their pro-rata share of the market.

The increases in claim costs, coupled with the inability of insurers to recoup their losses through premium increases, has resulted in the poor financial performance of New York malpractice insurers. A soon-to-be-published study by the NAIC shows that New York insurers' aggregate loss ratio ranks fourth worst in the nation at 144.25%. This means that for each dollar of premium, insurers expect to pay out \$1.44. Only three states have worse loss ratios than New York—Illinois (170%), Nevada (166%), and Mississippi (160%).<sup>32</sup> Of course, if premiums actually rose to the levels apparently needed to cover the costs of insurance, the malpractice crisis would only be worsened because more providers would be unable to afford it.

**Table 10: Loss Ratios by State—2002**

<b>Year</b>	<b>National Rank—Worst Ratio</b>	<b>Loss Ratio</b>
Illinois	1	170.27
Nevada	2	165.69
Mississippi	3	159.79
New York	4	144.25

Source: National Association of Insurance Commissioners, *Medical Malpractice Insurance Report: A Study of Market Conditions and Potential Solutions to the Recent Crisis*, draft report (July 14, 2002). Final report forthcoming.

The rating process provides additional evidence of the remaining four insurers' financial strain. The A.M. Best Company is the leading provider of financial strength ratings for the insurance industry. MLMIC and Physicians Reciprocal Insurers (PRI) have withdrawn from the voluntary rating process, receiving a rating of NR-4. According to Best, the rating category NR-4 is, "Assigned to companies that were assigned a Best's Rating but request that their ratings not be published because the companies disagree with Best's rating conclusion".<sup>33</sup> MLMIC explained its decision to withdraw as follows:

Because MLMIC has little control over the rates established by the Insurance Superintendent for New York physicians (its largest business) and must fund a majority of the deficits incurred by New York's involuntary malpractice pool

<sup>31</sup> Based on conversations with Medical Liability Mutual Insurance Company, which administers the MMIP program. Deficit numbers are undiscounted. 2004 deficit based on June 30, 2004, unaudited financial statement; 2003 data based on audited 2003 financial statement.

<sup>32</sup> National Association of Insurance Commissioners, *Medical Malpractice Insurance Report: A Study of Market Conditions and Potential Solutions to the Recent Crisis*, draft report (July 14, 2002). Final report forthcoming, Table 13.

<sup>33</sup> A.M. Best ratings accessed via [www.ambest.com](http://www.ambest.com)

(MMIP), it became increasingly difficult to overcome these unique constraints in the A.M. Best rating process.<sup>34</sup>

HIC continues to be rated by Best but has a rating of C++ (Marginal). According to Best, this rating is “assigned to companies that have, in our opinion, a marginal ability to meet their current obligations to policyholders, but are financially vulnerable to adverse changes in underwriting and economic conditions.” Academic Health Professionals Insurance Association (AHPIA) has a B (Fair) rating, which is “assigned to companies that have, in our opinion, a fair ability to meet their current obligations to policyholders, but are financially vulnerable to adverse changes in underwriting and economic conditions.”

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<sup>34</sup> “AM Best Withdrawal,” Medical Liability Mutual Insurance Company press release, 20 August 2004. Accessed via Web site, [www.mlmic.com](http://www.mlmic.com).

## V. Impact on Access to Services

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Consumer groups and provider associations have offered different conclusions about the impact of increased malpractice costs and exposure on access. The GAO published a detailed study in 2003, “Medical Malpractice: Implications of Rising Premiums on Access to Health Care,” which suggests that despite evidence of reduced access for certain services in some states, malpractice premiums did not affect access to care on a widespread basis. This finding appears to hold true for New York where access to some services—for example, obstetrics—appears to be decreasing.

The GAO conducted an in-depth study of nine states, five of which were identified as problem states by the AMA, to determine whether actions taken by providers in response to increasing malpractice premiums had constrained access (“the GAO Access Study”). In each of the five problem states—Florida, Mississippi, Nevada, Pennsylvania, and West Virginia—the GAO confirmed instances where access to emergency surgery and newborn deliveries had decreased because of malpractice pressures. In these cases, patients had to travel farther for care.<sup>35</sup> However, based upon its analysis of increases in Medicare beneficiaries’ utilization of spinal surgery, joint revisions and repairs, and mammography between 2000 and 2002, the GAO concluded that there is not a widespread problem in access to services.

### Provider Perspective

Lack of definitive evidence of a widespread diminution in access to services generally is not conclusive with respect to access problems for specific services. Thus, according to the American College of Obstetricians and Gynecologists (ACOG), seven upstate New York counties have no OB/GYNs whatsoever,<sup>36</sup> six have only one,<sup>37</sup> and 12 have two to four OB/GYNs.<sup>38</sup> In addition, rural Sidney Hospital announced in December 2004 that it was applying for permission to cease providing obstetrical services. Although there are multiple factors related to physicians’ decisions on where to practice, the concern is that medical malpractice premiums are contributing to pressing access issues.

The downstate region has experienced service constrictions as well. In August of 2003, the Brooklyn Birthing Center closed when its insurer ceased to provide malpractice insurance for midwives. In September 2003, Elizabeth Seton Birthing Center closed its Manhattan

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<sup>35</sup> For example, in Jacksonville, Florida, there was a reduction in emergency department on-call surgical coverage when, in May 2003, 19 general surgeons took leaves of absence because of malpractice costs, reducing the city’s general surgical capacity by an estimated 33%. Within the first 11 days of the physicians’ leave, 120 transfers took place.

<sup>36</sup> Essex, Hamilton, Lewis, Seneca, Cortland, Tioga, and Schoharie. American College of Obstetricians and Gynecologists, “Counties With Inadequate Access to Maternity Care” (Albany: ACOG District II/NY, January 2003).

<sup>37</sup> Allegany, Schuyler, Chenango, Warren, Montgomery, and Green. Ibid.

<sup>38</sup> Franklin, St. Lawrence, Columbia, Oswego, Sullivan, Wayne, Yates, Livingston, Wyoming, Genesee, Orleans, and Cattaraugus. Ibid.

location when its carrier raised premiums by 400%.<sup>39</sup> And, in December 2004, Interfaith Medical Center announced that it was seeking permission to terminate its obstetrical services.

## Physician Supply

According to ACOG, 212 New York OB/GYNs stopped delivering babies altogether from the beginning of 2002 through the middle of 2003.<sup>40</sup> Of those OB/GYNs remaining in the market, 36% are over 60 years of age and are likely to retire over the next decade.<sup>41</sup> However, a survey of 226 students at the State University of New York Downstate College of Medicine suggests that the retirees' replacements may be slow to come. While 62.6% of students surveyed reported that they would or did consider OB/GYN as their chosen specialty, only 5.3% actually planned to pursue it.<sup>42</sup> Similarly, in a national survey of medical school clerkships, students ranked OB/GYN last as a specialty of interest to them. In a 2004 ACOG NY survey of residency programs, 50% of graduating OB/GYN residents indicated that they will leave New York State, up from 45% in 2002.<sup>43</sup> The composition of OB/GYN residents is also changing, with the number of positions filled by graduates of U.S. medical schools decreasing from 81% in 2000 to 70% in 2004. This decrease suggests that a specialty once popular among American-educated physicians is becoming much less so, which may be a result of the anticipated burden of medical liability premiums.<sup>44</sup>

## Changes in Practice

Nationally, the number of practicing OB/GYNs per 100,000 population remained relatively stable from 1998 to 2002, though it decreased by more than 4% in New York.<sup>45</sup> This statistic alone is suggestive of physician supply, but does not reveal additional important information about changes in physician practice patterns that may further affect access to obstetrical services.

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<sup>39</sup> Michelle O'Donnell, "A Birthing Center Falls Prey to Rising Insurance Costs," *New York Times*, 24 August 2003.

<sup>40</sup> American College of Obstetricians and Gynecologists, "More than 100,000 Women Could Lose Their Obstetrician July 1st" (Albany: ACOG District II/NY, July 11, 2003). Accessed via Web site, October 18, 2004, [http://www.acog.org/from\\_home/acog\\_districts/dist\\_notice.cfm?recno=1&bulletin=1211](http://www.acog.org/from_home/acog_districts/dist_notice.cfm?recno=1&bulletin=1211).

<sup>41</sup> Id., "Ob-Gyns Warn Policy Makers: July 1 Increase Could Further Reduce Access to Care," ACOG District II, New York (July 1, 2004). Accessed via Web site, October 18, 2004, [http://www.acog.org/from\\_home/acog\\_districts/dist\\_notice.cfm?recno=1&bulletin=1425](http://www.acog.org/from_home/acog_districts/dist_notice.cfm?recno=1&bulletin=1425).

<sup>42</sup> Ibid.

<sup>43</sup> Id., *Red Action Alert: Women's Health Care at Risk* (August 2004).

<sup>44</sup> National Resident Match Program, 2004 data accessed via [www.nrmp.org](http://www.nrmp.org), Table 5. In 2000 and 2004, U.S. medical graduates filled, on average, 73% and 70% of all positions respectively.

<sup>45</sup> In 1998 there were 13.9 OB/GYNs per 100,000 population in the United States, and in 2002 there were 13.6. In New York, the comparable numbers declined from 19.5 per 100,000 in 1998 to 18.7 in 2002. American Medical Association, *Physician Characteristics and Distribution in the United States* (Washington, D.C., 2000 and 2004).

According to a survey undertaken by ACOG, nationwide, one in seven ACOG Fellows reported that they had stopped practicing obstetrics because of the risk of liability claims.<sup>46</sup> The fear of litigation led 22% of OB/GYNs to decrease the amount of high-risk obstetric care they provide, while, for the same reason, 14.8% stopped offering or performing vaginal births after cesareans, 9.2% reduced the number of deliveries they perform, 12.3% decreased the number of gynecologic surgical procedures they perform, and 5.6% no longer perform any gynecologic surgery. According to the ACOG survey, the cost and limited availability of liability insurance led 25.2% of respondents to decrease the amount of high-risk obstetric care they provide, 12.2% to decrease the number of deliveries they perform, 14.8% to decrease the number of gynecologic surgical procedures they perform, and 5.4% to stop performing major gynecologic surgery. With respect to New York, an unpublished survey by the New York Office of ACOG reported that about 67% of obstetricians and gynecologists in New York State have reduced their services in some way in response to the rising costs of malpractice premiums.<sup>47</sup>

### Other Perspectives

Identifying whether access to certain specialty services has declined as a result of rising medical malpractice costs is complicated. Differing perspectives on the issue are evidenced by reports such as *The Doctor Is In: New York's Increasing Number of Doctors*,<sup>48</sup> by several well-respected consumer advocacy organizations concerned about constraining consumer rights through possible changes to the current liability system.

The report, for example, states that New York's physician supply is not decreasing overall, and concludes that contrary reports from physicians and physician groups are unfounded scare tactics. However, observations about the number of total physicians statewide are not dispositive as to whether there are shortages in particular areas of the State and in particular specialties. Physician workforce analyses are routinely performed on areas even smaller than a county, for example, in order to identify physician shortage areas relevant to Federal and State designations of medically underserved areas (MUAs) and health professions shortage areas (HPSAs). As noted above, changes in practice patterns can also have a marked impact on the availability of services, irrespective of the number of reported physicians in a given specialty.

In addition, the number of physicians engaged in patient care per 100,000 population in New York actually declined between 1998 and 2002 by 1.5%, compared with a 1.9% increase nationally, with the decline steeper in the specialty of OB/GYN (see table 11). New York has always tended to have more physicians per 100,000 population than the

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<sup>46</sup> American College of Obstetricians and Gynecologists, "Medical Liability Survey Reaffirms More Ob-Gyns Are Quitting Obstetrics" (Washington, D.C., July 16, 2004). Accessed via Web site, October 18, 2004, [http://www.acog.org/from\\_home/publications/press\\_releases/nr07-16-04.cfm](http://www.acog.org/from_home/publications/press_releases/nr07-16-04.cfm).

<sup>47</sup> American College of Obstetricians and Gynecologists, "\$91 Million Malpractice Award Increases Threat to Women's Access to Quality Ob-Gyn Care" (Albany: ACOG District II/NY, December 12, 2002). Accessed via Web site, October 18, 2004, [http://www.acog.org/from\\_home/acog\\_districts/dist\\_notice.cfm?recno=1&bulletin=1117](http://www.acog.org/from_home/acog_districts/dist_notice.cfm?recno=1&bulletin=1117).

<sup>48</sup> Frank Clemente, Blair Horner, Arthur Levin, *The Doctor Is In: New York's Increasing Number of Doctors* (Albany: NYPIRG, October 2004).

national average—a situation presumably enjoyed by the State’s residents, who have had greater choice and access as a result—but these ratios have declined over time, and more so in OB/GYN, suggesting that attrition has indeed occurred over the years of concern.

**Table 11: Number of Patient Care Physicians per 100,000 Population—All Specialties and Obstetrician/Gynecologists in New York State**

	1998			2002			% Change 1998–2002		
	Office-based practice	Hospital-based practice	Total	Office-based practice	Hospital-based practice	Total	Office-based practice	Hospital-based practice	Total
<b>Total</b>	219	112	331	217	108	326	-0.7	-3.2	-1.5
<b>OB/GYN</b>	14.6	4.8	19.5	13.9	4.8	18.7	-4.8	0.0	-4.1

Source: American Medical Association, *Physician Characteristics and Distribution in the United States*, 2000 and 2004 editions (Washington, D.C., 2000 and 2004).

The report also refers to New York State’s regulatory framework, which has empowered the State Insurance Department to hold down annual physician malpractice premium increases to about 7%–8.5% in recent years, as evidence that physician premiums are not increasing. However, as discussed, these regulated premium increases tell only part of the story. The less evident story is that within the average increase, some areas and some specialties have experienced dramatically higher increases; some insurance carriers are leaving the market voluntarily or involuntarily due to financial stress resulting from inadequate premium rates; and rate increases for the MMIP, serving those physicians who cannot obtain insurance in the voluntary, commercial market, have been in the double digits (see table 4).

## VI. Factors Contributing to Premium Increases

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The literature suggests that several factors have contributed to the current medical malpractice crisis. These factors include escalating malpractice awards, insurers' deteriorating return on investment, and high reinsurance costs. The literature suggests that escalating malpractice claim costs resulting from larger awards and settlements is the greatest single factor contributing to premium increases.

### Escalating Malpractice Awards and Claim Frequency

It is difficult to evaluate recent trends in malpractice claims and awards because no central database exists at the Federal level.<sup>49</sup> Despite the lack of this central resource, the available data suggest that malpractice jury awards and claim payments have increased dramatically since the mid-1990s. The data on claim frequency are less consistent, with some studies suggesting no increase and others noting modest increases over this same period.

Data that will soon be published from the National Association of Insurance Commissioners (NAIC), a membership organization of state insurance commissioners<sup>50</sup>, shows increases in both paid and incurred losses over the 1999–2002 period. Paid losses are cash payments made in a year irrespective of the year in which the claim was filed. Incurred losses reflect the insurer's expected costs based on claims reported in that year.<sup>51</sup> The NAIC reports cumulative increases in paid and incurred losses of 15% and 64%, respectively, over the 1999–2002 period and cites insurers losses as the driving force behind medical malpractice rate increases over the past several years.<sup>52</sup>

Data from the Physician Insurers Association of America (PIAA), which represents doctor-owned medical liability companies, suggest that average physician claim payments increased by 40% over the 1998–2002 period, from \$232,156 to \$323,975.<sup>53,54</sup>

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<sup>49</sup> The U.S. Department of Health and Human Services operates the National Practitioner Data Bank (NPDB). The NPDB is intended to serve as a central resource for medical malpractice settlements and judgments for physicians and practitioners but the data are considered to be unreliable. General Accounting Office, *National Practitioner Data Bank: Major Improvements Are Needed to Enhance Data Bank's Reliability*, GAO-01-130 (Washington, D.C., November 2000), p. 16.

<sup>50</sup> Among other things, the NAIC tries to promote uniformity in state regulation and legislation as it concerns the insurance industry. It has done so through the adoption of a uniform blank for insurance companies' annual financial reports, a zone system for the triennial examinations of insurance companies, a standard valuation law for reserves, standard non-forfeiture benefits, and model laws for valuation of the insurance companies securities.

<sup>51</sup> GAO, p. 16.

<sup>52</sup> National Association of Insurance Commissioners, *Medical Malpractice Insurance Report: A Study of Market Conditions and Potential Solutions to the Recent Crisis*, draft report (July 14, 2002). ("NAIC Report"). Final report forthcoming.

<sup>53</sup> "PIAA, NPDB Show Medical Malpractice Costs Still Rising," Physician Insurers Association of America press release, 4 May 2004.

<sup>54</sup> CBO, *Limiting Tort Liability*, p. 4.

The increase in average claim costs is being driven in part by the considerable increase in jury awards. The median malpractice jury award increased from \$475,000 in 1996 to more than \$1 million in 2001 and 2002, according to Jury Verdict Research, a private research firm, as reported by the Joint Economic Committee of the United States Congress and the American Academy of Actuaries.<sup>55</sup> Data from PIAA show that payments of more than \$1 million doubled over the period 1997-2001 and, in 2001, represented almost 8% of paid claims.<sup>56</sup>

Data on the number of claims submitted each year suggest that the number of claims is stable or increasing only slightly. The Insurance Information Institute reports that a study by AON Risk shows increases of 3% per year in claim volume, yet the CBO Issue Brief indicates that claim frequency has remained relatively constant at 15 malpractice claims filed for every 100 physicians.<sup>57,58</sup>

New York appears particularly vulnerable to “mega” awards and “mega” settlements. In 2002, as illustrated in table 12, New York courts were responsible for seven out of the top 10 malpractice verdicts in the country.<sup>59</sup> While most cases typically settle for less than the amount of the verdict, “mega” awards, or the well-founded fear thereof, escalate “mega” settlement costs, illustrated in table 13.

**Table 12: Top 10 Malpractice Verdicts, 2002**

Verdict Amount	State
94,810,000	New York (Brooklyn)
90,939,000	New York (Brooklyn)
80,000,000	New York (Suffolk)
78,500,000	Florida
64,000,000	New York (Bronx)
61,662,000	New York (Brooklyn)
59,300,000	California
56,145,000	New York (Manhattan)
43,500,000	California
25,870,000	New York (Brooklyn)

Source: “100 Largest Verdicts of 2002,” *National Law Journal*. Accessed via Web site, [www.verdictsearch.com/news/specials/020303verdicts\\_chart.jsp](http://www.verdictsearch.com/news/specials/020303verdicts_chart.jsp).

<sup>55</sup> Testimony of Jim Hurley, American Academy of Actuaries, Subcommittee on Health, Committee on Energy and Commerce, U.S. House of Representatives, Joint Economic Committee, 27 February 2003, p. 7.

<sup>56</sup> Statement by the Physician Insurers Association of America, 29 January 2003.

<sup>57</sup> Insurance Information Institute, *Medical Malpractice* (October 2004). Accessed via Web site, [www.iii.org](http://www.iii.org).

<sup>58</sup> CBO, *Limiting Tort Liability*, p. 4.

<sup>59</sup> “100 Largest Verdicts of 2002,” *National Law Journal*. Accessed via Web site, [www.verdictsearch.com/news/specials/020303verdicts\\_chart.jsp](http://www.verdictsearch.com/news/specials/020303verdicts_chart.jsp).

**Table 13. Sample of Top New York State Malpractice Sustained Awards/Settlements 1999–2004**

Sustained award or settlement	County	Year
\$50,123,293	New York	2002
\$16,690,970	New York	2000
\$14,315,752 <sup>a</sup>	Bronx	2003
\$14,275,466	Queens	1999
\$14,000,000 <sup>a</sup>	Bronx	2004
\$12,000,000 <sup>a</sup>	New York	2001
\$11,000,000 <sup>a</sup>	Kings	1998
\$10,615,148	Kings	2000
\$9,625,891 <sup>a</sup>	New York	2003
\$9,614,890	Queens	2000

Source: Data compiled by the law firm of Saretsky Katz Dranoff & Glass, L.L.P.

a. Denotes settlement.

The tendency toward large awards and settlements adds up. Thus, New York carriers reported 2002 total incurred losses to the NAIC of more than \$1 billion, 84% higher than in Illinois, the state with the next largest incurred losses. Paid losses in New York for 2002 totaled over \$747 million, 114% higher than in Illinois.<sup>60</sup>

**Table 14: Direct Losses Incurred and Paid by State, 2002**

State	Direct Losses Incurred	State	Direct Losses Paid
New York	1,014,523,451	New York	747,760,697
Illinois	550,770,710	Illinois	348,920,540
Florida	490,792,352	Florida	315,156,922
California	326,527,222	California	256,206,589
Pennsylvania	315,959,973	New Jersey	232,317,898

Source: National Association of Insurance Commissioners, *Medical Malpractice Insurance Report: A Study of Market Conditions and Potential Solutions to the Recent Crisis*, draft report (July 14, 2002). Final report forthcoming.

The GAO Premium Report, CBO Issue Brief, the NAIC report and a study by Ken Thorpe of NAIC data published in the January 21, 2004, issue of *Health Affairs* (the “Thorpe study”) suggest that increasing claim costs are the single largest factor in medical malpractice premium increases.

<sup>60</sup> National Association of Insurance Commissioners, Tables 8 and 10.

## **Deteriorating Returns on Investment**

Insurers' investment yields have decreased since the late 1990s, though the impact of these decreased yields is not sufficient to explain the large premium increases during those years. Malpractice insurers are able to pay out more in losses and expense than the dollars they collect in premiums by relying upon investment income, which is earned over the lag period between the payment of premiums and payment of losses and is included as a component of the actuarially determined cost of malpractice coverage.<sup>61</sup>

The GAO Premium Report found that most state laws restrict medical malpractice insurers to conservative investments.<sup>62</sup> The GAO reports that in 2001, the 15 largest insurance companies writing medical malpractice insurance maintained 79% of their investments in bonds.<sup>63</sup> Although the annual yields for bonds have decreased since the late 1990s, insurers are not losing money on their investments but they are earning lower rates of return, which means that the premium subsidy, as described above, has decreased. Another study found that the net yield for malpractice firms decreased from 8% in 1998 to 6% in 2002.<sup>64</sup> However, these decreases in investment income do not account for the large increases in premiums during this period of time.

## **Increased Reinsurance Costs**

Malpractice insurers purchase reinsurance to protect themselves against large, unpredictable losses. According to the American Academy of Actuaries and the GAO Premium Report, reinsurance costs have increased since the late 1990s for two reasons—increased claim severity and reinsurance losses related to the events of September 11, 2001. The GAO reports that reinsurance premium rates in their sample states had increased as much as 50–100% since 1998.<sup>65</sup> The Academy points out that since reinsurers cover cases with the greatest losses, they are disproportionately affected by increases in claim severity. Thorpe, the GAO Premium Report, and the Academy suggest that increased reinsurance costs, although contributing to premium increases, are having a lesser effect than decreases in investment income or escalating claim severity. Discussions with captives in New York suggest that as of 2004, there is no market for aggregate reinsurance. These captives cannot purchase reinsurance for aggregate losses and, therefore, have no protection against catastrophic claim costs, which will have to be funded by the captive hospital members.

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<sup>61</sup> Statement of Jim Hurley, American Academy of Actuaries, Subcommittee on Health, Committee on Energy and Commerce, U.S. House of Representatives, 27 February 2003.

<sup>62</sup> GAO, p. 24.

<sup>63</sup> Ibid.

<sup>64</sup> Thorpe, p. 4.

<sup>65</sup> GAO, p. 32.

## VII. Disconnection Between Malpractice and Negligence

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Studies evaluating the rates of adverse events in hospitals versus malpractice claims suggest that the two are poorly correlated. Less than half, and by some estimates as few as 17%, of malpractice claims involve negligence and few negligent adverse events result in a malpractice claim.<sup>66,67,68</sup>

Three studies conducted in California, New York, and Utah/Colorado relied on large-scale medical record reviews of hospital discharges to determine the rate of adverse events and negligent adverse events.<sup>69</sup> The findings suggest rates of adverse events ranging from 2.9% to 4.6% and rates of negligent adverse events of 0.8% to 1.0%.<sup>70,71</sup>

The New York and Utah/Colorado studies attempted to link negligent injuries to claims and found little relationship between the two. The New York study reported that only 2% of negligent injuries resulted in a claim and only 17% of claims involved a negligent injury.<sup>72</sup> The Utah/Colorado study similarly found that only 2.5% of negligent adverse events resulted in a claim and that, of malpractice claims filed, only 22% involved negligence.<sup>73</sup> Other studies, however, have suggested that the percentage of malpractice claims involving a negligent injury is higher—ranging from 25% to 47% of malpractice claims.<sup>74</sup>

The effectiveness of the tort system in distinguishing between, and rewarding, cases involving negligence versus cases with no negligence is debatable. Three studies reviewing malpractice claims filed with insurers suggest that claims involving negligence are 1.9 to 4.3 times more likely to result in payment versus claims not involving negligence.<sup>75</sup> The

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<sup>66</sup> David M. Studdert, M. M. Mello, Troyen A. Brennan, “Medical Malpractice,” *New England Journal of Medicine* (January 15, 2004): 285.

<sup>67</sup> M. White, “The Value of Liability in Medical Malpractice,” *Health Affairs* (Fall 1994): 76.

<sup>68</sup> Eric J. Thomas, David M. Studdert, Helen R. Burstin, E. John Orav, Timothy Zeena, Elliott J. Williams, K. Mason Howard, Paul C. Weiler, Troyen A. Brennan, “Incidence and Types of Adverse Events and Negligent Care in Utah and Colorado,” *Medical Care* 38, no. 3 (March 2000): 7.

<sup>69</sup> A 1973 study by the U.S. Department of Health, Education, and Welfare reviewed 21,000 records from California hospitals and found a rate of 4.6% adverse events and 0.8% negligent adverse events. A study conducted in New York by Harvard researchers in the 1980s reviewed 30,000 hospital records and 3,500 malpractice claims found adverse event rates of 3.7% and negligent adverse events of 1.0%. Troyen A. Brennan, Lucian L. Leape, Nan M. Laird, Liesi Hebert, A. Russell Localio, Ann G. Lawthers, Joseph P. Newhouse, Paul C. Weiler, Howard H. Hiatt, “Incidence of Adverse Events and Negligence in Hospitalized Patients, Results of the Harvard Medical Practice Study I,” *New England Journal of Medicine* 324 (February 1, 1991): 370–76. A 1992 study of discharges in Utah and Colorado found rates of 2.9% adverse events, and rates of negligent adverse events of 0.94% (Utah) and 0.80% (Colorado). D. M. Studdert, E. J. Thomas, H. R. Burstin, B. I. Zbar, E. J. Orav, T. A. Brennan, “Negligent Care and Malpractice Claiming Behavior in Utah and Colorado,” *Medical Care* 38, no. 3 (2000): 253, 255.

<sup>70</sup> Studdert et al., “Medical Malpractice,” p. 285.

<sup>71</sup> Thomas et al., p. 4.

<sup>72</sup> Studdert et al., “Medical Malpractice,” p. 285.

<sup>73</sup> Studdert et al., “Negligent Care,” pp. 253, 255.

<sup>74</sup> White, p. 78,79.

<sup>75</sup> *Ibid.*

researchers in the New York study cited above, however, found that negligence was not predictive of payment for a malpractice claim<sup>76</sup> but that severity of the plaintiff's disability was predictive of payment.

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<sup>76</sup> T. M. Brennan, C. M. Sox, H. R. Burstin, "Relation Between Negligent Adverse Events and the Outcomes of Medical-Malpractice Litigation," *New England Journal of Medicine* (December 26, 1996): 1965.

## VIII. Medical Malpractice Reforms Adopted by States

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Medical malpractice is covered under tort law, which is almost exclusively governed by state law. States have implemented many types of tort reforms but it is difficult to evaluate the effect of each initiative because reforms are often passed in a package such that the impact of an individual reform cannot be isolated. In addition, studies use varying outcomes measures—number of claims filed, insurer profitability, premiums—so that it is difficult to generalize to a single outcome. Despite these limitations, however, the research suggests that limits on damages decrease the number of claims filed and the amount plaintiffs recover, and increase insurer profitability.<sup>77,78</sup> The collateral source rule, although often studied with other reforms, appears to reduce claim costs. The research on the other reforms is less consistent, with some studies showing a decrease in malpractice activity while others show no effect or an increase.

**Caps on Non-economic Damages.** Non-economic damages are payments for nonmonetary losses, such as pain, suffering, and anguish. Eighteen states (see table 15) have statutes limiting non-economic damages with caps ranging from \$250,000 to \$750,000.<sup>79</sup>

Studies analyzing the effects of tort reforms suggest that capping non-economic damages reduces insurers' losses by 11.7% to 17%.<sup>80,81</sup> One of these studies reported overall premium reductions of 17.1%.<sup>82</sup> In addition, the 2003 HHS Study found that states with caps up to \$350,000 experienced average premium increases of 18% from 2001 to 2002, compared with increases of 45% in states without a cap.<sup>83</sup> HHS also found that since California enacted the Medical Injury Compensation Reform Act of 1975, which caps noneconomic damages at \$250,000, premiums increased 167% compared with 505% in the rest of the country over the 1975–2001 period.<sup>84</sup>

*New York:* No cap on non-economic damages.

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<sup>77</sup> Congressional Budget Office, *The Effects of Tort Reform: Evidence from the States* (Washington, D.C., June 2004), p. viii.

<sup>78</sup> Office of Technology Assessment, U.S. Congress, "Impact of Legal Reforms on Medical Malpractice Costs," OTA-BP-H-119, (Washington, D.C., September 1993), p. 2.

<sup>79</sup> CBO, *The Effects of Tort Reform*, p. 6. Twenty-three states have enacted caps on non-economic damages but in five of the states the law was found to violate the state constitution (Alabama, Illinois, New Hampshire, Oregon, and Washington).

<sup>80</sup> Thorpe, p. W4-26.

<sup>81</sup> W. Kip Viscusi and Patricia H. Born, "Damages Caps, Insurability and the Performance of Medical Malpractice Insurance," Olin Discussion Paper Series (Cambridge: Harvard Law School, March 2004), p. 15. Accessed via Web site, [www.law.harvard.edu/programs/olin\\_center](http://www.law.harvard.edu/programs/olin_center).

<sup>82</sup> Thorpe, p. W4-26.

<sup>83</sup> Office of the Assistant Secretary for Planning and Evaluation, *Addressing the New Health Care Crisis: Reforming the Medical Litigation System to Improve the Quality of Health Care* (Washington, D.C.: U.S. Department of Health and Human Services, March 3, 2003), p. 23.

<sup>84</sup> *Ibid.*

**Caps on Punitive Damages.** Punitive damages are awarded to punish a defendant for “willful and wanton” conduct.<sup>85</sup> Thirty-three states restrict punitive damages.<sup>86</sup> Twenty-five of these states limit punitive damages in ways including outright bans (six states), fixed dollar caps of \$250,000 to \$10 million, and caps equal to a multiple of compensatory awards.<sup>87</sup> Other states have procedural reforms, such as requiring a separate hearing (13 states).

Research on the effect of limiting punitive damages on malpractice claims, insurer costs, and premiums is inconclusive. Some studies have reported no significant effect of punitive damage reforms,<sup>88</sup> whereas others have reported decreased recoveries,<sup>89</sup> although no significant effect on premium.<sup>90</sup>

***New York:***

- 1) No limit on punitive damages;
- 2) Standard of proof for punitive damages: Gross negligence or wanton, reckless or willful conduct.

*Note: Punitive damages have never been awarded in a medical malpractice case in New York.*

**Collateral Source Rule.** The collateral source rule bars the defense from admitting information on any compensation the plaintiff has received from other sources (for example, health insurance or workers compensation) as evidence at trial. Twenty-three states have enacted reforms in this area, which permit evidence of other payments to be introduced at trial, permit offsets of such amounts from any award of damages, or both.<sup>91</sup>

The collateral source rule was generally included with other reforms in studies evaluating states’ experience. Two studies, which included collateral source with restrictions on punitive damages and, in one case, a cap on non-economic damages, found that the whole package was associated with lower claim costs.<sup>92</sup> A study of NAIC data, which did isolate modifications to the collateral source rule as a reform, found that “discretionary offsets,” those offsets at the judge’s discretion, were associated with lower claim costs. Some studies, as reported by the Office of Technology Assessment (OTA) in its 1993 review of empirical research on medical malpractice, have found lower payments per claim in states with collateral source offsets but none of the OTA-reviewed studies reported an impact on malpractice premiums.<sup>93</sup>

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<sup>85</sup> CBO, *The Effects of Tort Reform*, p. 2.

<sup>86</sup> *Ibid.*, p. ix. Thirty-four states have passed statutes limiting punitive damages, but in Illinois such a statute was found to violate the State constitution.

<sup>87</sup> *Ibid.*, p. ix.

<sup>88</sup> Thorpe, p. W4-26.

<sup>89</sup> Albert Yoon, “Damage Caps and Civil Litigation: An Empirical Study of Medical Malpractice Litigation in the South,” *American Law and Economics Review* 3, no. 2 (2001): 216.

<sup>90</sup> Viscusi and Born, p. 19.

<sup>91</sup> CBO, *The Effects of Tort Reform*, p. 6.

<sup>92</sup> *Ibid.*, pp. 12–13.

<sup>93</sup> Office of Technology Assessment, p. 69.

**New York:** Evidence of collateral source benefits must be presented at trial and may be used to reduce awards.

**Joint And Several Liability.** Joint and several liability holds any liable party responsible for the full amount of the award regardless of his or her degree of fault. A single defendant, therefore, may be responsible for all damages regardless of that defendant's degree of fault. States' reforms in this area include limiting the defendants' damages based upon an apportionment of fault, allowing application only when a single defendant is responsible (for example, more than 50% at fault), limiting applicability to economic damages, and restricting its application to instances where defendants acted in a concerted effort.<sup>94</sup> Forty-two states currently limit joint and several liability in some way.<sup>95</sup>

Research in this area yields conflicting results. Several studies found no effect from limiting joint and several liability.<sup>96</sup> Two studies did find premium reductions but those findings were limited: in one case modifications to joint and several liability were coupled with other reforms in the analysis<sup>97</sup> and in the other study joint and several liability had an effect on medical malpractice premiums in only one of the study years.<sup>98</sup>

**New York:** If any co-defendant's liability is found to be 50% or less of the total liability, the liability of that defendant for non-economic damages will not exceed the defendant's share. If defendant's liability is 51% or more, that defendant is a guarantor of the payment of all non-economic damages. Defendants are jointly and severally liable for all economic damages regardless of their percentage share of actual liability.

**Periodic Payments of Future Damages.** Periodic payment reforms allow payments to be staggered over time. Reforms may allow the court to alter payments if plaintiffs' situations change.<sup>99</sup>

**New York:** If a case goes to trial, future damages are paid in periodic payments through an annuity, except for 1) damages related to loss of services, consortium, wrongful death; 2) pain and suffering of less than \$500,000 and 35% over \$500,000; 3) 35% of economic damages.

**Statutes of Limitations.** Reforms in this area reduce the amount of time in which a lawsuit must be filed after an injury occurs.

**New York:**

- 1) Adults: 2 \_ years after the date of the act that gave rise to the injury.
- 2) Children: 2 \_ years from 18th birthday up to a maximum of 10 years.

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<sup>94</sup> CBO, *The Effects of Tort Reform*, p. 5.

<sup>95</sup> *Ibid.*, p. 4.

<sup>96</sup> *Ibid.*, pp. 12–13; Thorpe, pp. W4-26.

<sup>97</sup> CBO, *The Effects of Tort Reform*, pp. 12–13.

<sup>98</sup> *Ibid.*

<sup>99</sup> *Ibid.*, p. 8.

**Contingency Fee Cap.** Contingency fee caps limit the lawyer's percentage of the award.

*New York:* Caps contingency fees according to the following schedule.

- 30% of the first \$250,000
- 25% of the next \$250,000
- 20% of the next \$500,000
- 15% of the next \$250,000
- 10% of the amount over \$1.25 million

This yields a maximum fee of \$275,000 for awards up to \$1.25 million, and \$275,000 plus 10% of amounts over \$1.25 million for awards over \$1.25 million.

**Other Reforms.** States have adopted other types of tort reforms to decrease costs and increase fairness. These reforms include victim compensation funds, which are no-fault funds to compensate victims of certain types of medical malpractice, and court-sponsored alternate dispute resolution programs.

Table 15 lists the states that have adopted up to four of the major reform types.

**Table 15: Four Major Tort Reforms by State**

State	Cap on Non-economic Damages	Cap on Punitive Damages	Joint-and-Severall Liability	Collateral Source Rule
Alabama		√		√
Alaska	√	√	√	√
Arizona		√	√	√
Arkansas		√	√	
California		√	√	
Colorado	√	√	√	√
Connecticut			√	√
Florida	√	√	√	√
Georgia		√	√	
Hawaii	√		√	√
Idaho	√	√	√	√
Illinois			√	√
Indiana		√		√
Iowa		√	√	√
Kansas	√	√		
Kentucky		√	√	√
Louisiana		√	√	
Maine				√
Maryland	√			
Massachusetts			√	
Michigan	√		√	√
Minnesota	√	√	√	√
Mississippi	√	√	√	
Missouri		√	√	√
Montana	√	√	√	√
Nebraska			√	
Nevada	√	√	√	
New Hampshire		√	√	
New Jersey		√	√	√
New Mexico			√	
New York		√	√	√
North Carolina		√		
North Dakota	√	√	√	√
Ohio	√	√	√	√
Oklahoma	√	√		√
Oregon		√	√	√
Pennsylvania			√	
South Carolina		√		
South Dakota		√	√	
Texas	√	√	√	
Utah		√	√	
Vermont			√	
Virginia		√		
Washington			√	
West Virginia	√		√	
Wisconsin	√	√	√	
Wyoming			√	

Note: The table omits laws that were enacted but later determined legally invalid.

Source: Congressional Budget Office, *The Effects of Tort Reform: Evidence from the States* (Washington, D.C., June 2004).

## Conclusion

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A survey of the literature on the malpractice crisis coupled with a review of information specific to New York shows that there are real reasons to be concerned about the availability and affordability of malpractice coverage, with concomitant concerns about the impact of malpractice trends on provider willingness to perform certain types of medical services, which may in turn be affecting patients' access to care. The reasons for the crisis are multi-faceted, with escalating claims costs, decreased investment income, and increased reinsurance costs all contributing to an increase in the cost of available insurance. The degree of financial weakness in and failures of malpractice carriers is a great cause for concern. However, if this concern were addressed by increasing premiums rather than by reducing claims costs, the problem for health care providers and patient access would only be exacerbated because more providers would simply be unable to afford coverage. GNYHA looks forward to working with all the relevant parties to help ensure that the health care system and, above all, the welfare of patients, are better served.