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

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President King, members of the Florida Senate, distinguished guests…it is a great pleasure to be here today to present the major findings and recommendations of our white paper *Medical Malpractice Caps: The Impact of Non-Economic Damage Caps on Physician Premiums, Claims Payout Levels, and Availability of Coverage*. Special thanks to President King and Senator Ken Pruitt for inviting me to speak at this workshop on medical malpractice.

My firm, Weiss Ratings, Inc. of Palm Beach Gardens, Florida, is in the business of rating and analyzing insurance companies and other financial services companies nationwide. Unlike our major competitors, we never accept payment from the rated companies for our ratings. We derive our revenues exclusively from the sale of our ratings to public libraries, consumers, and professionals.

For many years we have been studying medical malpractice insurers with growing concern:

- In the early 1990s, we noticed many med mal insurers becoming more aggressive, expanding the business into new markets, and *underpricing* their policies.

- In the late 1990s, we saw many insurers begin to play catch up, jacking up premiums sharply.

- Then, in the last three years, the financial markets turned down and the investment revenues of the insurers declined. This put further strong pressure on companies to raise premiums – not only on medical malpractice polices, but other lines of business as well.

- Now, in recent months, we have been watching the spreading malpractice crisis with even greater concern. We have seen the impact on doctors and patients. We have seen the growing public outcry. And as objective researchers, we have also witnessed one additional problem: *Nearly every major study on this crisis has been sponsored or financed by one of the interested parties.*

That's why we decided to develop a white paper on this issue, which we published at the beginning of this month. I am attaching a copy of the white paper to my testimony today and making it available to you and your staff.

No organization has paid us to produce this white paper. We have no relationship with any of the parties to this debate. We have financed our studies exclusively out of our own funds, and we have not sold the study to anyone. It is purely our contribution to the public policy debate.

Here are the primary findings and insights from our study.

Caps on non-economic damages do seem to help insurance companies reduce their payouts for claims. However, it is unclear how or if the caps reduce the premiums insurance companies charge for medical malpractice policies. In fact, we found that from 1991 to 2002,

- caps failed to slow the rise in median premiums.

- Plus, among states *with* caps, we found relatively fewer states that were able to keep their premiums flat . . . while in states without caps, we found relatively *more* that were able to accomplish that goal.

Clearly, there must be other important factors that drive premium rates higher, and, indeed, we have identified six:

Factor 1: The medical inflation rate was 75% between 1991 and 2002.

Factor 2: The insurance companies had to play catch up from those earlier years when they were underpricing their policies.

Factor 3: Many insurers needed to shore up their reserves for policies already in force.

Factor 4: Most companies suffered declines in their income from investments.

Factor 5: Some companies suffered a decline in their financial health and needed to restore their capital.

Factor 6: Toward the second half of the 1990s, there was a decline in the number of medical malpractice insurers, probably reducing the supply of policies, despite continuing demand for them.

Our paper documents how each of these—medical inflation, the catch-up syndrome, under-reserving, declining investments, financial health concerns, and diminishing supply—played a role in driving premiums higher.

Since we released our white paper two weeks ago, we have received numerous comments from insurance companies, physicians, and others. We welcome these comments and look forward to further debate. However, I would like to correct a couple of misconceptions.

First, some groups apparently believe that Weiss is fundamentally opposed to caps. That is not the case. Rather, our position is that legislators should put proposals involving non-economic damage caps on hold until convincing evidence can be produced to demonstrate a true benefit to doctors in the form of reduced medical malpractice costs.

Second, some groups have questioned our methodology: Shouldn't we use the mean instead of the median? What about medical specialties not included in the study? What about other years?

As noted at the outset, no one has paid us to conduct this research. We chose the approaches we believe were the most appropriate:

- *The median* is recommended by the primary data providers to our study, The National Practitioners Data Bank, in order to help prevent distortions by skewed data.

- *The specialties* we used include a fair representation of high- and average-risk areas.

- *The years* we chose provide the longest time horizon for which consistent data are available.

True, different methodologies will no doubt lead to different results. However, no matter which approach is used, the following questions will still beg for answers:

- Why did some states fail to prevent sharp rises in premiums despite caps?

- Conversely, how were other states able to hold down their premium rates even without caps?

- What broader reforms are needed other than caps?

- There are four parties in this debate: The insurance companies, the health providers, the trial lawyers, and the patients. What sacrifices are appropriate and how can they be spread fairly to all parties?

Our analysis is a view, if you will, from 60,000 feet. It is too soon to answer these questions with any specificity or certainty. So in the weeks ahead, we will be delving further into more data with the goal of shedding additional light on these telling questions. We plan to look at each state, company, specialty, and year in greater depth, and we will be releasing further analysis as soon as it becomes available.

However, based on our research so far, it is not too soon to make some broad proposals:

First, we believe that a significant burden for a solution lies with the insurance industry.

- State insurance regulators should review and revise their parameters for approving rate increases so that premiums are priced realistically based on the underwriting experience in their state. This way, if premiums must go up, they will tend to rise in smaller increments, over a longer period of time, giving doctors an opportunity to plan and adapt to the changes.

- Insurers should pay more attention to their underwriting profits and losses, independent of any contribution from investment income.

- Insurers should also not allow marketing to compromise prudent actuarial analyses and planning.

Second, we believe that the medical community should also make changes, assuming more responsibility for policing itself. Specifically . . .

- We propose that the state track the number of claims filed against physicians. The tracking should be relative to the average for each specialty and in relation to each physician's level of activity. Based on these and similar measures, physicians experiencing a level of claims that is far above average should be subject to further scrutiny and possible actions.

- We propose a comprehensive database with information on specific doctors, clinics, hospitals, specialties, and procedures regarding the relative risk of errors or malpractice, in order to make more informed choices.

- We propose that all health care providers be encouraged to contribute information to this database in a standard format and without risk of retaliation.

- We propose that this database be made available for easy access by consumers, with appropriate caveats and privacy protections. With this kind of data in the public domain, we believe consumers will naturally gravitate toward the lowest risk situations, thereby reducing the risk and cost for all concerned.

Overall, my message is simple: Caps may well play a role in a broad-based solution, but they alone are NOT the solution.

Thank you. I will be happy to take questions about our white paper should you have any.