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MEDICAL MALPRACTICE INSURANCE

Multiple Factors Have Contributed to Premium Rate Increases

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Mr. Chairman and Members of the Subcommittee:

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

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

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

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

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

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

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

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

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

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

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

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

Background

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

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

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

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

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

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

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

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

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

Rising Paid Losses Increase Insurers' Expectations of Required Premiums

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

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

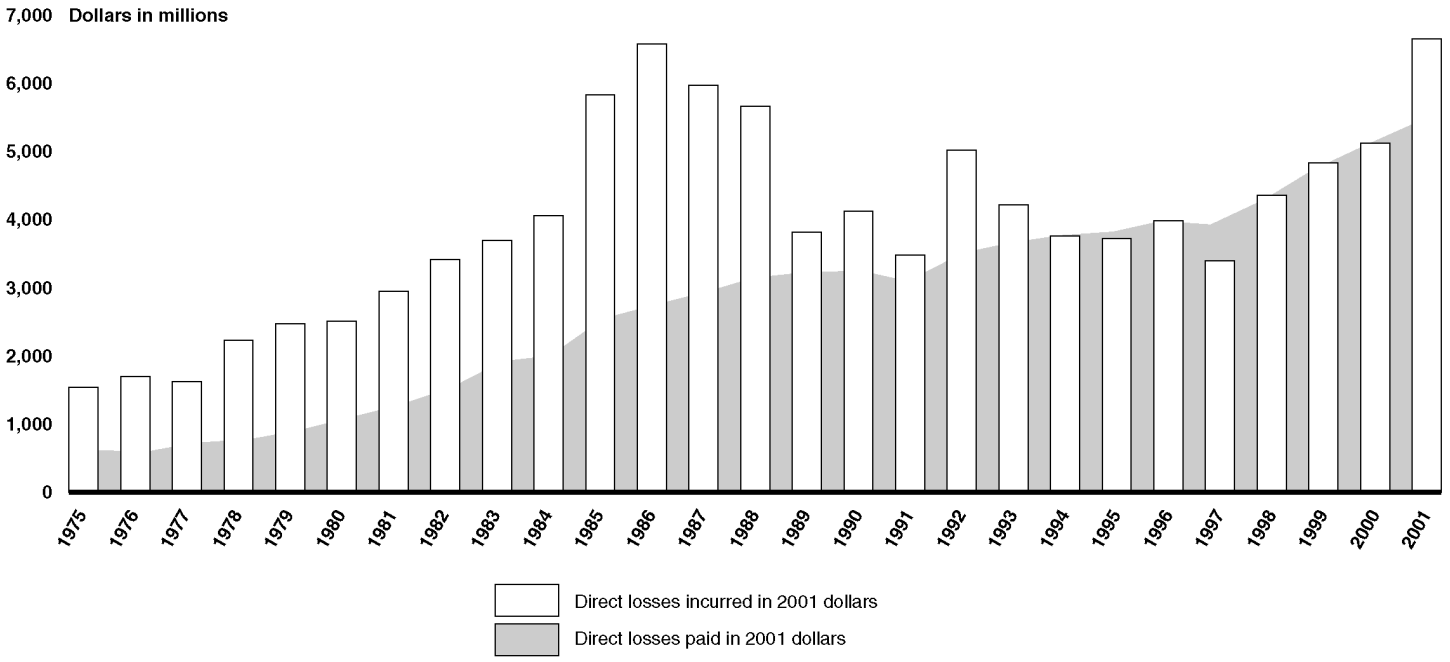
[9] We identified several factors suggesting that this market was not anticompetitive. That is, these factors suggested that insurers in this market were not charging premium rates that were inconsistent with expected losses.

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

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

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

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



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

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

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

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

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

Declining Investment Income Has Affected Premiums

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

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

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

Downward Pressure on Premium Rates Has Decreased as Profitability Has Declined

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

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

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

Reinsurance Premium Rates Have Increased

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

The Medical Malpractice Market Moves through Hard and Soft Insurance Cycles

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

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

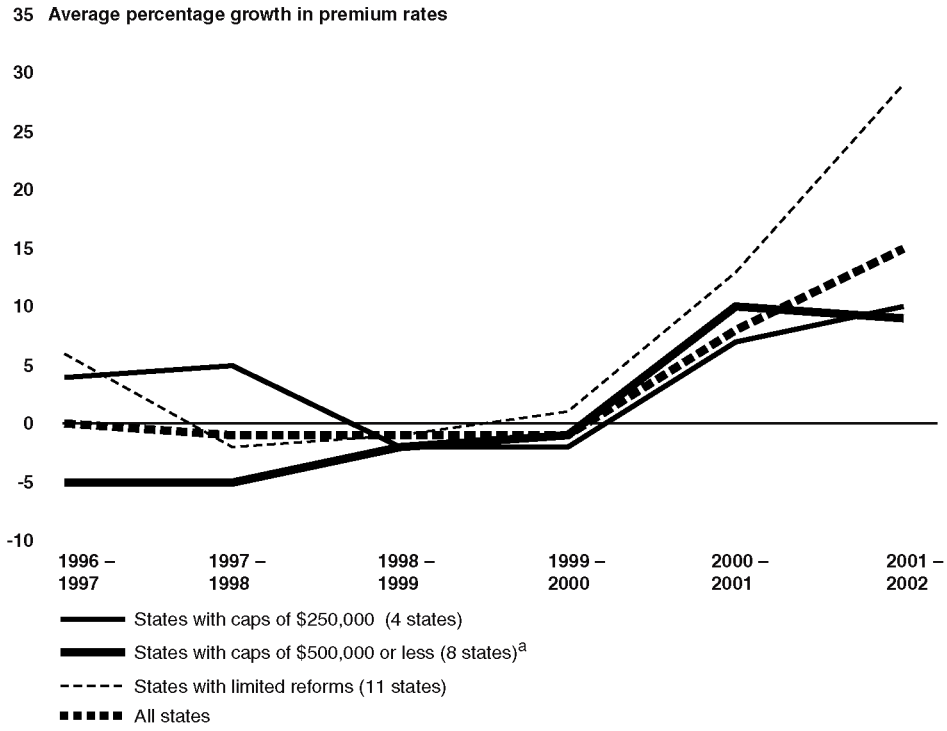
In order to constrain the rate of growth in malpractice insurance premiums, states have adopted various tort reform measures, some of which include placing caps on monetary awards for noneconomic damages. Premium rates reported for the physician specialties of general surgery, internal medicine, and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

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

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

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

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



Source: MLM.

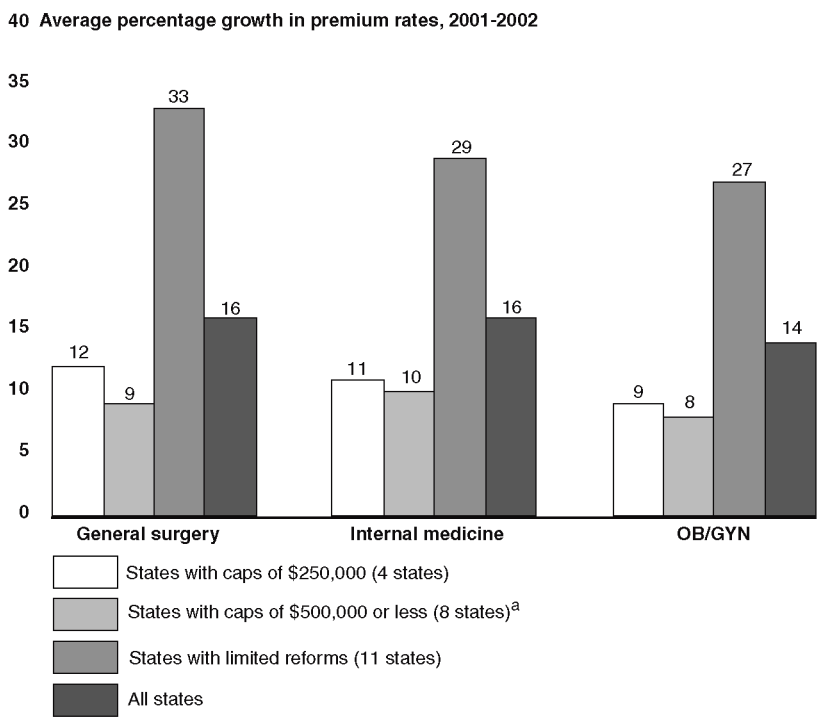
Notes: GAO analysis of MLM base premium rates, excluding discounts, rebates, and surcharges, reported for the specialties of general surgery, internal medicine, and OB/GYN.

Premiums are adjusted for inflation to 2002 dollars.

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

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

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



Source: MLM.

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

Premiums are adjusted for inflation to 2002 dollars.

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

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

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

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

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

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

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

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

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

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

Conclusions

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

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

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

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

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

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

Contacts and Acknowledgements

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

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