MONTANA SENATE
2005 LEGISLATURE

ROLL CALL

JUDICIARY

DATE 3-4-05

NAMES	PRESENT	ABSENT	EXCUSED
SEN. MICHAEL WHEAT, CHAIRMAN	✓		
SEN. BRENT CROMLEY			✓
SEN. AUBYN CURTISS			✓
SEN. JON ELLINGSON			
SEN. JESSE LASLOVICH	✓		
SEN. JEFF MANGAN			✓
SEN. DAN McGEE			✓
SEN. LYNDA MOSS	✓		
SEN. JERRY O'NEIL	✓		
SEN. GERALD PEASE	✓		
SEN. GARY PERRY	✓		
SEN. JIM SHOCKLEY	✓		
VALENCIA LANE, LSD	✓		
MARI PREWETT, COMMITTEE SECRETARY	✓		

DATE 3-4-05

SENATE COMMITTEE ON Judiciary

BILLS BEING HEARD TODAY: HB 24, HB 26, HB 64, HB 25

HB 222, HB 331

PLEASE PRINT

NAME	PHONE	REPRESENTING	BILL #	SUPPORT	OPPOSE
Mona Jamison	442-5581	Mt Orthopedic Soc	24, 26, 64, 25, 222, 331	✓	
Mona Jamison	442-5581	DOCTORS CO.	24, 25, 26, 64, 222, 331 w. amd	✓	
MARK RABOLD	4928789	ACEP	HB222	✓	
Pat Melby	442-7450	Mt Med Ass'n	24, 25, 26, 64, 222, 331		
Al Smith	443-3124	MTLA	24, 25, 26, 64, 331, 222	✓	X
LARRY E. RILEY	523-2500	Utah Med Ins Assoc	24, 25, 26, 222, 331		
Jim Jinks	916 552 6715	USAA	331		X
Larry Kibbee	360-770 6925	PCIAA	331		X
Tami McCall	670-3084	Deaconess Billings Clinic	24, 25, 26, 64, 331		
Tom Ebzery	441-7531	SV Holy Rosary, St James W'mart	HB222, 24, 25, 26, 64	X	
Barbara Ranf	442-2405 Ext 104	Mt Chamber	24, 26, 64, 25, 222	X	
Roger Melgland	442-9555	IIAM	331		X
Steve Yeakel	443 1674	MT Council for Maternal & Child Health	24, 25, 26, 64, 222, 331	X	
Riley Johnson	443-3797	NFIB	24, 25, 26, 64, 222, 331	X	
Gloria Hermann	449-2334	Ophthalmology/Otolaryngology		X	

VISITOR REGISTER

PLEASE LEAVE PREPARED STATEMENT WITH COMMITTEE SECRETARY

DATE 3-4-05

SENATE COMMITTEE ON Judiciary

BILLS BEING HEARD TODAY: HB 24, HB 26, HB 25, HB 64, HB 222, HB 331

PLEASE PRINT

NAME	PHONE	REPRESENTING	BILL #	SUPPORT	OPPOSE
Mike Schwartzer MD	628-1260	Rocky Mountain Health Care	HB 24 25 26 222 331	X	
John Wilson MD	2386589	Self	24 25 26 222 331	✓	
Aaron Billin MD	665-2511	Self	24, 25, 26 222, 331	X	
FRED MCMURRY MD	238 1650	self	25 26 24 222 331	X	
Bradley W. Anderson MD	252-0244	Self	25, 26, 24 222, 331	X	
Mark Rumm, MD	238-2637	Dearmont Bill's Clinic	24, 26, 64, 25	X	
Jacqueline Lenmark	2-0230	Am. Ins. Assn	HB 24, 25, 26, 222	X	
Jacqueline Lenmark	2-0230	Am Ins. Assn	HB 331		X
Joe Mazurek	457-2000	Blue Cross Blue Shield	HB 25, 25, 26 222, 64	X	
Joe Mazurek	457-2000	"	HB 331		X
Daniel Dave	652-0767	Hat Farm In	HB 331		X
MARK TAYLOR	443-6820	MHA	24, 25, 26 64, 222, 331	X	
Frank Cote	3-9070	FUMIC	HB 331		X
Don Allen	3-7531	MTAIFA	HB 331		X

VISITOR REGISTER

PLEASE LEAVE PREPARED STATEMENT WITH COMMITTEE SECRETARY

DATE 3-4-05

SENATE COMMITTEE ON Judiciary

BILLS BEING HEARD TODAY: HB 24, HB 26, HB 25, HB 64

HB 222, HB 331

PLEASE PRINT

NAME	PHONE	REPRESENTING	BILL #	SUPPORT	OPPOSE
MARTI L. WARREW	443-1160	Montana Podiatric Medical Assoc	HB24, HB25,26 HB222	✓	

VISITOR REGISTER

PLEASE LEAVE PREPARED STATEMENT WITH COMMITTEE SECRETARY

OTHER

DOCUMENTS

Americans for Insurance Reform
"PROTECTING RIGHTS, NOT WRONGS"

Medical Malpractice Insurance: Stable Losses/Unstable Rates 2004

October 2004

Introduction and Summary of Findings

Over the last three years, this country has endured a series of protests, walk-outs and strikes by doctors protesting skyrocketing medical malpractice insurance rates for some high-risk specialties. The insurance industry and organized medicine have blamed the crisis on the legal system and have lobbied extensively for laws to limit compensation to injured patients.

A tremendous amount of fear and anger has been generated among doctors and patients alike due to rising malpractice insurance rates. But the question has always remained – have insurers charged rates that are justified by their claims experience, or is there another reason why they have raised rates so dramatically for doctors in the last three years?

Americans for Insurance Reform (AIR), a coalition of over 100 consumer groups around the country, has provided an answer to this question. *Stable Losses/Unstable Rates 2004* examines trends in medical malpractice insurance – both premiums and claims - over the past 30 years. AIR has found that the amount medical malpractice insurers have paid out, including all jury awards and settlements, directly track the rate of medical inflation. On the other hand, medical insurance premiums charged by insurance companies have not corresponded to increases or decreases in payouts. Rather, they have risen and fallen in sync with the state of the economy, reflecting gains or losses experienced by the insurance industry's market investments.

This new 2004 study makes two major findings:

- First, contrary to what the insurance and medical lobbies have alleged, the year 2003 saw no "explosion" in medical malpractice insurer payouts or costs to justify skyrocketing rate hikes. **In fact, rather than exploding, inflation-adjusted payouts per doctor have *dropped* for the last two years.** Payouts (in constant dollars) have been essentially flat or dropping since the mid-1980s.

- Second, **medical malpractice insurance premiums rose faster in 2003 than was justified by insurance payouts.** The price hikes, which began in 2001, are similar to the rate hikes of the past, which occurred in the mid-1980s and mid-1970s and were not connected to actual payouts either. Rather, they reflect a weakened economy and losses experienced by the insurance industry's market investments and their perception of how

80 Broad Street ❖ Suite 1710 ❖ New York, NY 10004-3307 ❖ (917) 438-4608 ❖ Fax (212) 764-4298
info@insurance-reform.org ❖ www.insurance-reform.org ❖ (A project of the Center for Justice & Democracy)

MTLA

much they can earn on the investment "float" (which occurs during the time between when premiums are paid into the insurer and losses paid out by the insurer) that doctors' premiums provide them.

Background

The nation's insurance companies are advancing a legislative agenda to limit liability for doctors, hospitals, HMOs, nursing homes and drug companies that cause injury. Federal and state lawmakers and regulators (and the general public) are being told by medical and insurance lobbyists that doctors' insurance rates are rising due to increasing claims by patients, rising jury verdicts and exploding tort system costs in general.

The insurance industry argues and, worse, convinces doctors to believe that patients who file medical malpractice lawsuits are being awarded more and more money, leading to unbearably high losses for insurers. Insurers state that to recoup money paid to patients, medical malpractice insurers are being forced to raise insurance rates or, in some cases, pull out of the market altogether.

Since insurers say that jury verdicts are the cause for the current "crisis" in affordable malpractice insurance for doctors, the insurance industry insists that the only way to bring down insurance rates is to limit an injured consumer's ability to sue in court.

Insurance rates for doctors have skyrocketed twice before: in the mid-1970s and in the mid-1980s, each "crisis" occurring during years of a weakened economy and dropping interest rates. Each of these periods was followed by a wave of legislative activity to restrict injured patients' rights to sue for medical malpractice. Medical and insurance lobbyists told legislators that changes in tort law were needed to reduce medical malpractice insurance rates.

However, history shows that the insurance industry has not cut, and has no plans to cut, insurance premiums as a consequence of tort restrictions. The American Insurance Association (AIA) and representatives of the American Tort Reform Association (ATRA) have already gone on record admitting this, with the AIA stating on March 13, 2002, "the insurance industry never promised that tort reform would achieve specific premium savings."

The Center for Justice & Democracy's 1999 study, *Premium Deceit —The Failure of "Tort Reform" to Cut Insurance Prices*, found that tort law limits enacted since the mid-1980s did not lower insurance rates in the ensuing years. Some states that resisted enacting any "tort reform" experienced low increases in insurance rates or loss costs relative to the national trends, and some states that enacted major "tort reform" packages saw very high rate or loss cost increases relative to the national trends. In other words, there was no correlation between "tort reform" and insurance rates.

More recently, Weiss Ratings, an independent insurance-rating agency, found that between 1991 and 2002, states with caps on noneconomic damage awards saw median doctors' malpractice insurance premiums rise 48 percent – *a greater increase than in states without caps.*

In states without caps, median premiums increased only 36 percent. Weiss speculated that state regulation of insurance premium increases made the difference.[1]

Similarly, an August 2004 paper from the National Bureau of Economic Research found: "Surprisingly, there seems to be a fairly weak relationship between malpractice payments (for judgments and settlements) and premiums – both overall and by specialty." "Past and present malpractice payments do not seem to be the driving force behind increases in premiums. Premium growth may be affected by many factors beyond increases in payments, such as industry competition and the insurance underwriting cycle.[2]

The "liability insurance crises" of the mid-1970s and mid-1980s were ultimately found to be caused not by legal system excesses but by the economic cycle of the insurance industry. Just as these liability insurance crises were found to be driven by this cycle and not a tort law cost explosion as many insurance companies and others had claimed, the "tort reform" remedy pushed by these advocates failed.

As this study, Weiss and NBER confirm, it will fail again.

The *Stable Loss/Unstable Rates 2004* Study

AIR, under the direction of actuary J. Robert Hunter (Director of Insurance for the Consumer Federation of America, and former Federal Insurance Administrator and Texas Insurance Commissioner), has produced a comprehensive study of medical malpractice insurance, examining specifically what insurers have taken in and what they've paid out, in constant dollars, over the last 30 years through 2003. AIR examined everything that medical malpractice insurers have paid in jury awards, settlements and other costs over the last three decades, and compared these actual costs with the premiums that insurers have charged doctors, as well as with the economic cycle of the insurance industry.

This AIR study explores whether or not there is, as the insurance industry claims, an explosion in lawsuits, jury awards or tort system costs justifying an increase in insurance premium rates, or whether premium increases simply reflect the economic cycle of the insurance industry, driven by interest rates and investments.

The Insurance Industry's Economic Cycle

Insurers make most of their profits from investment income. During years of high interest rates and/or excellent insurer profits, insurance companies engage in fierce competition for premium dollars to invest for maximum return. Insurers severely underprice their policies and insure very poor risks just to get premium dollars to invest. This is known as the "soft" insurance market.

---

[1] Jyoti Thottam, "He Sets Your Doctor's Bill; A Chastened Insurer," *Time Magazine*, June 9, 2003.

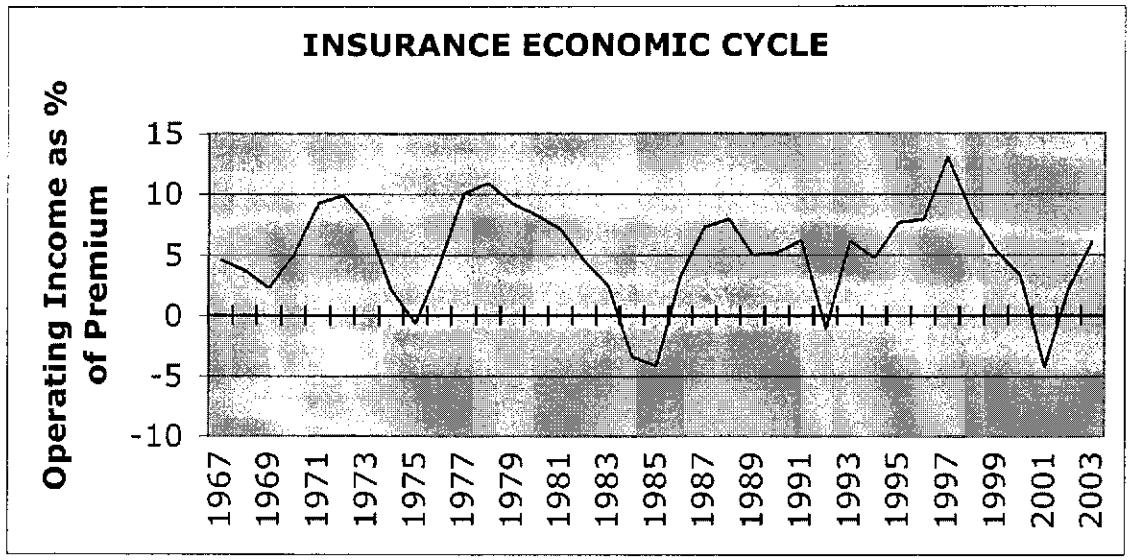
[2] Katherine Baicker & Amitabh Chandra, NATIONAL BUREAU OF ECONOMIC RESEARCH, *The Effect of Malpractice Liability on the Delivery of Health Care* (Aug. 2004), at 14 & 20.

But when investment income decreases — because interest rates drop or the stock market plummets or the cumulative price cuts make profits become unbearably low — the industry responds by sharply increasing premiums and reducing coverage, creating a "hard" insurance market usually degenerating into a "liability insurance crisis."

A hard insurance market happened in the mid-1970s, precipitating rate hikes and coverage cutbacks, particularly with medical malpractice insurance and product liability insurance. A more severe crisis took place in the mid-1980s, when most liability insurance was impacted. Again, beginning in 2001, the country started experiencing a "hard market," this time impacting property as well as liability coverages with some lines of insurance seeing rates going up 100% or more.

The following Exhibit shows the national cycle at work, with premiums stabilizing for 15 years following the mid-1980s crisis. (The 1992 data point was not a classic cycle bottom, but reflected the impact of Hurricane Andrew and other catastrophes in that year.)

Exhibit 1. The Insurance Cycle



Prior to late 2000, the industry had been in a soft market since the mid-1980s. The strong financial markets of the 1990s had expanded the usual six- to ten-year economic cycle. No matter how much they cut their rates, the insurers wound up with a great profit year when investing the float on the premium in this amazing stock and bond market. (The "float" occurs during the time between when premiums are paid into the insurer and losses paid out by the insurer —*e.g.*, there is about a 15 month lag in auto insurance and a 5 to 10 year lag in medical malpractice.) Further, interest rates were relatively high in recent years as the Fed focused on inflation.

But in 2000, the market started to turn with a vengeance and the Fed cut interest rates again and again. This took place well before September 11th. The terrorist attacks sped up the price

increases, collapsing two years of anticipated increases into a few months and leading to what some seasoned industry analysts see as gouging.[3] However, the increases we are witnessing are mostly due to the cycle turn, not the terrorist attack or any other cause. This is a classic economic cycle bottom.

Smoking Guns

AIR tested two hypotheses advanced by the insurance industry: First, if large jury verdicts in medical malpractice cases or any other tort system costs are having a significant impact on the overall costs for insurers' and are therefore the reason behind skyrocketing insurance rates, then losses per doctor should be rising faster than medical inflation over time. Second, if lawsuits or other tort costs are the cause of rate increases for doctors -- rather than decreasing interest rates and other economic factors -- those losses should be reflected in rate increases in line with such losses, not in ups and downs that instead reflect the state of the economy, the well-documented insurance economic cycle (Exhibit 1), interest rates, the stock market or the level of insurers' investment income.

AIR finds both hypotheses are completely false, demonstrated by Exhibits 2 and 3 below. First, these charts show that since 1975, medical malpractice paid claims per doctor have tracked medical inflation very closely (slightly higher than inflation from 1975 to 1985 and flat since). In other words, payouts have risen almost precisely in sync with medical inflation. Moreover, contrary to what the insurance and medical lobbies have alleged, the years from 2001 through 2003 saw no "explosion" in medical malpractice insurer payouts or costs to justify sudden rate hikes. In fact, rather than exploding, inflation-adjusted payouts per doctor *dropped* from 2001 to 2003. These data confirm that neither jury verdicts nor any other factor affecting total claims paid by insurance companies that write medical malpractice insurance have had much impact on the system's overall costs over time.

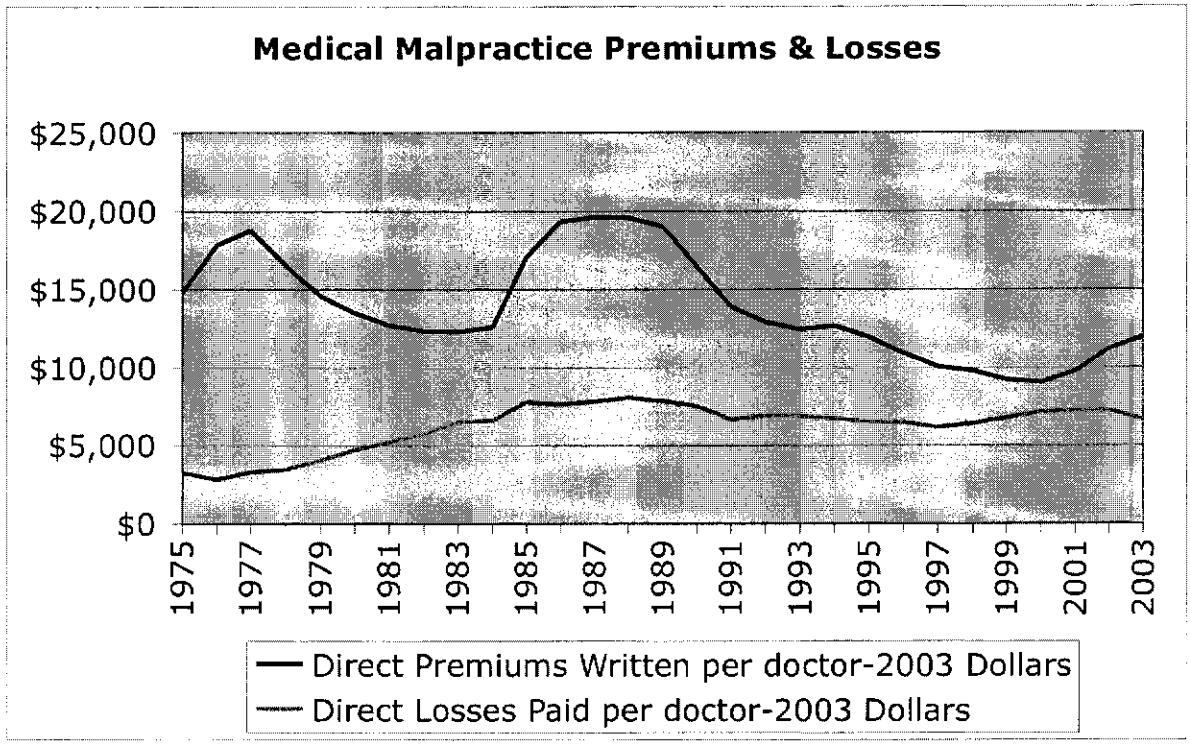
Second, while payouts closely track medical inflation, medical malpractice premiums are quite another thing. They do not track costs or payouts in any direct way. Since 1975, the data show that in constant dollars, per doctor written premiums — the amount of premiums that doctors have paid to insurers — have gyrated almost precisely with the insurer's economic cycle, which is driven by such factors as insurer mismanagement and changing interest rates, not by lawsuits, jury awards, the tort system or other causes. Moreover, medical malpractice insurance premiums rose much faster in 2002 and 2003 than was justified by insurance payouts. This hike is similar to the rates hikes of the past, which occurred in the mid-1980s and mid-1970s and were not connected to actual payouts.

In sum, the results of AIR's analysis illustrated in Exhibits 2 and 3 are startling; premiums rise and fall with the insurance industry's economic cycle, as illustrated in Exhibit 1, but losses paid do not.

---

[3] "[T]here is clearly an opportunity now for companies to price gouge – and it's happening.... But I think companies are overreacting, because they see a window in which they can do it." Jeanne Hollister, consulting actuary, Tillinghast-Towers Perrin, quoted in, "Avoid Price Gouging, Consultant Warns," *National Underwriter*, January 14, 2002.

Exhibit 2



Sources: A.M. Best and Co. special data compilation for AIR, reporting data for as many years as separately available (premiums and losses); American Medical Assoc. (number of non-federal doctors, 1975, 1980, 1985, 1986, 1990, 1992-2002; other years estimated); Bureau of Labor Statistics (CPI).[4] See Exhibit 3 for underlying data.

Definitions:

- **"Direct Premiums Written"** is the amount of money that insurers collected in premiums from doctors during that year.
- **"Direct Losses Paid"** is what insurers actually paid out that year to people who were injured – all claims, jury awards and settlements – plus what insurance companies pay their own lawyers to fight claims.[5]

[4] We calculate the paid losses on a per doctor basis to remove from the trend we are studying the effect of the ever increasing number of doctors in America. We acknowledge that the number of doctors includes a certain number of doctors that are retired or otherwise not in the medical malpractice system, but since we are interested in overall loss trends over time, and since the percentage of doctors in that category should not vary much year to year, this fact should not significantly impact our results.

[5] "Paid losses" are a far more accurate reflection of actual insurer payouts than what insurance companies call "incurred losses." Incurred losses are not actual payouts. They include payouts but also reserves for possible future claims – *e.g.*, insurers' estimates of claims that they do not even know about yet. While incurred losses do exhibit more of a cyclical pattern, observers know that this is because in hard markets, as we are currently experiencing, insurers will increase reserves as a way to justify price increases. In fact, the current insurance "crisis" rests significantly on a jump in loss reserves in 2001. Historically, reserves have been later "released" to profits during the "softer" market years. For example, according to a June 24, 2002, *Wall Street Journal* front page investigative article, St. Paul, which until 2001 had 20 percent of the national med mal market, pulled out of the market after mismanaging its reserves. The company set aside too much money in reserves to cover malpractice claims in the

Exhibit 3

Year	Written Premiums (thousands)	Paid Losses (thousands)	Loss Ratio	Number of Doctors (Non-federal)	Medical Care Inflation (CPI-U)	Direct Premiums Written per Doctor	Direct Losses Paid per Doctor	Direct Premiums Written per Doctor-2003 Dollars	Direct Losses Paid per Doctor-2003 Dollars
1975	$865,208	$190,867	0.221	366,425	47.5	$2,361.21	$520.89	$14,793.63	$3,263.51
1976	$1,187,978	$188,545	0.159	381,000	52	$3,118.05	$494.87	$17,844.85	$2,832.17
1977	$1,423,091	$248,969	0.175	395,575	57	$3,597.53	$629.39	$18,782.87	$3,286.05
1978	$1,412,555	$294,456	0.208	410,151	61.8	$3,443.99	$717.92	$16,584.64	$3,457.17
1979	$1,405,991	$391,800	0.279	424,726	67.5	$3,310.35	$922.48	$14,594.96	$4,067.10
1980	$1,493,543	$521,849	0.349	439,301	74.9	$3,399.82	$1,187.91	$13,508.49	$4,719.91
1981	$1,616,470	$665,570	0.412	455,904	82.9	$3,545.64	$1,459.89	$12,728.37	$5,240.81
1982	$1,815,056	$847,543	0.467	472,507	92.5	$3,841.33	$1,793.72	$12,358.71	$5,770.92
1983	$2,033,911	$1,079,862	0.531	489,109	100.6	$4,158.40	$2,207.81	$12,301.59	$6,531.27
1984	$2,282,590	$1,197,979	0.525	505,712	106.8	$4,513.62	$2,368.90	$12,577.27	$6,600.97
1985	$3,407,177	$1,556,300	0.457	522,315	113.5	$6,523.22	$2,979.62	$17,104.06	$7,812.64
1986	$4,335,863	$1,709,883	0.394	547,222	122	$7,923.41	$3,124.66	$19,327.92	$7,622.12
1987	$4,781,084	$1,905,491	0.399	556,647	130.1	$8,589.08	$3,423.16	$19,647.27	$7,830.38
1988	$5,166,811	$2,128,281	0.412	566,072	138.6	$9,127.48	$3,759.74	$19,598.40	$8,072.85
1989	$5,500,540	$2,273,628	0.413	575,496	149.3	$9,557.91	$3,950.73	$19,051.81	$7,874.99
1990	$5,273,360	$2,415,117	0.458	584,921	162.8	$9,015.51	$4,128.96	$16,480.44	$7,547.78
1991	$5,043,773	$2,423,418	0.480	609,384	177	$8,276.84	$3,976.83	$13,916.31	$6,686.47
1992	$5,228,362	$2,808,838	0.537	633,846	190.1	$8,248.63	$4,431.42	$12,913.17	$6,937.35
1993	$5,469,575	$3,028,086	0.554	648,662	201.4	$8,432.09	$4,668.20	$12,459.73	$6,898.00
1994	$5,948,361	$3,174,987	0.534	661,960	211	$8,985.98	$4,796.34	$12,674.07	$6,764.89
1995	$6,107,568	$3,326,846	0.545	689,121	220.5	$8,862.84	$4,827.67	$11,961.82	$6,515.71
1996	$6,002,233	$3,556,151	0.592	717,335	228.2	$8,367.41	$4,957.45	$10,912.09	$6,465.10
1997	$5,864,218	$3,587,566	0.612	737,263	234.6	$7,954.04	$4,866.06	$10,090.03	$6,172.80
1998	$6,040,051	$3,957,619	0.655	757,865	242.1	$7,969.82	$5,222.06	$9,796.86	$6,419.19
1999	$6,053,323	$4,446,975	0.735	778,491	250.6	$7,775.71	$5,712.30	$9,234.05	$6,783.64
2000	$6,303,206	$4,988,474	0.791	793,211	260.8	$7,946.44	$6,288.96	$9,067.72	$7,176.36
2001	$7,288,933	$5,424,197	0.744	814,776	272.8	$8,945.93	$6,657.29	$9,759.20	$7,262.49
2002	$8,928,252	$5,806,463	0.650	831,645	285.6	$10,735.65	$6,981.90	$11,186.73	$7,275.26
2003	$10,142,575	$5,622,377	0.554	848,514	297.1	$11,953.34	$6,626.15	$11,973.46	$6,637.30

Sources: A.M. Best and Co. special data compilation for AIR, reporting data for as many years as separately available (premiums and losses); American Medical Assoc. (number of non-federal doctors, 1975, 1980, 1985, 1986, 1990, 1992-2002; other years estimated); Bureau of Labor Statistics (CPI).

A Word About Loss Ratios

Loss ratios are the percent of premiums that insurers pay out in claims. These ratios will drop during hard market years reflecting sudden rate hikes, as they did during the years 1985-1987, and as they did again after 2001, which this study shows. In fact, loss ratios are now the

---

1980s, so it "released" $1.1 billion in reserves, which flowed through its income statements and appeared as profits. Seeing these profits, many new, smaller carriers came into the market. Everyone started slashing prices to attract customers. From 1995 to 2000, rates fell so low that they became inadequate to cover malpractice claims. Many companies collapsed as a result. St. Paul eventually pulled out, creating huge supply and demand problems for doctors in many states. Christopher Oster and Rachel Zimmerman, "Insurers' Missteps Helped Provoke Malpractice 'Crisis,'" *Wall Street Journal*, June 24, 2002.

lowest they have been since 1995. Otherwise, they tend to trend up as insurers cut premiums during the soft market.

Exhibit 3 shows this precise phenomenon of steadily increasing loss ratios from 1988 through 2000. This simply demonstrates the insurance cycle at work, which is the point of this study. Insurers did not respond to higher loss ratios during these years by raising rates because they were making significant money from investments. In fact, during the soft market, insurers are expected to take a larger underwriting loss (a combined loss ratio over 100 percent) than during the hard market as they benefit from more investment income during these times. As we show, when this income drops, insurers will then raise rates and loss ratios will also drop. This is indeed what is now happening.

Conclusion

Stable Losses/Unstable Rates 2004 analyzes what medical malpractice insurers have taken in and what they've paid out over the last 30 years, including jury awards, settlements and other costs. Its findings are startling. While insurer payouts directly track the rate of medical inflation, medical insurance premiums do not. Rather, they rise and fall in relationship to the state of the economy. Not only has there been no "explosion" in lawsuits, jury awards or any tort system costs at any time during the last three decades, but the astronomical premium increases that some doctors have been charged during periodic insurance "crises" over this time period are in exact sync with the economic cycle of the insurance industry, driven by interest rates and investments. In 2001, rates began to spike, but payouts stayed flat. In other words, insurance companies raise rates when they are seeking ways to make up for declining interest rates and market-based investment losses and reduction in interest rates.

Medical Malpractice Caps

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

by

Martin D. Weiss, Ph.D.
Melissa Gannon
Stephanie Eakins

Weiss Ratings, Inc.

June 2, 2003
(Revised)

4176 Burns Road, Palm Beach Gardens, FL 33410 (561) 627-3300

MTLA

© Copyright 2003 by Weiss Ratings, Inc.
4176 Burns Road, Palm Beach Gardens, FL 33410
www.WeissRatings.com

Media Contacts
Elizabeth Kelley Grace, (561) 989-9855
and Ellen Yui, (301) 270-8571

Legislative and Regulatory Contact
Erich Parker, (202) 966-8550

Martin D. Weiss, Ph.D., chairman of Weiss Ratings, Inc., is among the nation's leading advocates for consumer financial safety. He holds a Doctorate from Columbia University and is the author of the national best-sellers, *Crash Profits: Make Money When Stocks Sink AND Soar* and *The Ultimate Safe Money Guide.*

Melissa Gannon is vice president of Weiss Ratings, Inc.

Stephanie Eakins is Weiss Ratings' lead analyst for the property and casualty insurance industry.

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

Table of Contents

Executive Summary 3

Introduction 5

Part 1. The Real Relationship between Caps and Med Mal Premiums 7

Part 2. Other Factors Driving Up Med Mal Premiums 9

Part 3. Conclusions and Recommendations 13

Appendix 1. States with Caps: Median Medical Malpractice Payouts/Premiums 1991 – 2002 16

Appendix 2. States without Caps: Median Medical Malpractice Payouts/Premiums 1991 – 2002 17

Appendix 3. Weakest Medical Malpractice Insurers 18

Appendix 4. Other Studies and Position Statements Published By Participants in This Debate 19

Medical Malpractice Caps

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

Executive Summary

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

Caps did reduce the burden on insurers...

- In states with caps, the median payout between 1991 and 2002 was 15.7% lower than the median in states without caps, despite the fact that many states did not impose the caps until late in the 12-year period.
- Moreover, in states with caps, the payouts increased by only 37.8% from 1991 to 2002, while the rate of increase in states without caps was 71.3%, or nearly double.

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

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

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

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

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

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

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

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

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

Recommendations:

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

Introduction

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

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

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

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

*Caps are adjusted annually for inflation.

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

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

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

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

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

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

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

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

Caps do reduce the burden on insurers...

Using data provided by the National Practitioner Data Bank, we compared the median payouts in the 19 states with caps to those in the 32 states without caps[4] for the period between 1991 and 2002, with the following results:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Part 2. Other Factors Driving Up Med Mal Premiums

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

1. Medical Cost Inflation

The medical inflation rate in the 12-year period was 75%[5] (i.e., $1 of medical expenses in 1991 cost $1.75 in 2002). However, throughout the country, insurers had a general tendency to let their premium increases lag behind the pace of medical inflation. This was most likely due to the extended soft market experienced by the entire property and casualty insurance industry in the 1990s, explained below.

2. The Cyclical Nature of the Insurance Market

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

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

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

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

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

---

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

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

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

4. A decline in investment income

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

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

- Now, aggravating their difficulties, they also needed to compensate for stock market losses. With falling stock prices and declining interest rates, investment income[6] for the entire property/casualty industry fell 23% in 2001 compared to 2000, and then *another* 2.5% in 2002; and we must assume that med mal insurers suffered a similar decline. Indeed, investment income is particularly critical for lines of business like med mal where the duration of claims payouts typically span several years.

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

5. Financial Safety

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

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

---

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

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

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

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

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

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

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

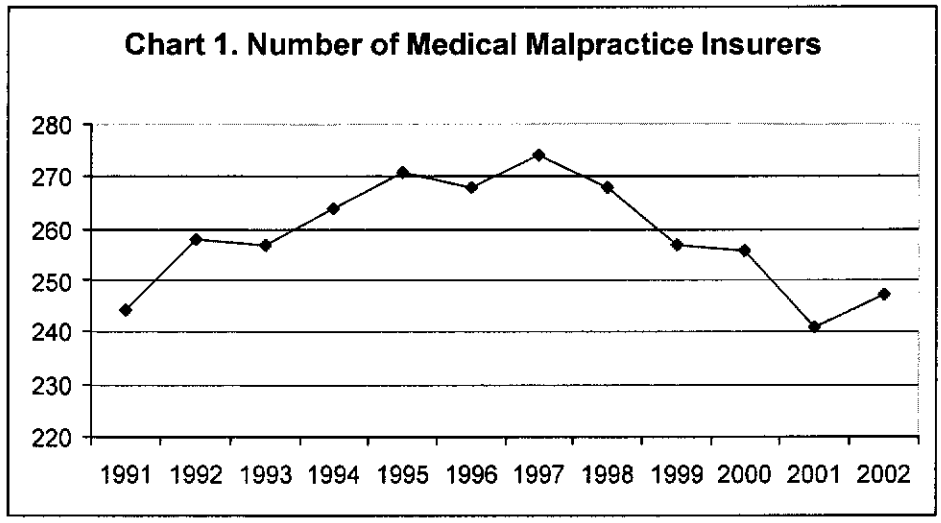
Weiss Safety Rating Category	2003 Med Mal Insurers	1999 Med Mal Insurers
Secure	65.5%	69.0%
Vulnerable	34.4%	31.0%

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

6. The Supply and Demand of Coverage

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

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



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

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

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

Part 3. Conclusions and Recommendations

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

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

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

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

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

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

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

Thus, by focusing on caps as a solution..

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

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

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

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

We recommend the following steps:

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

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

For many years, we have warned that rather than evaluating the property and casualty business based on total profits (including investment income), the focus should be on underwriting profits and losses, independent of investment income.[7] Had our warnings been heeded, premium rate increases may have risen gradually over time, rather than jumping suddenly during an already-painful bear market.

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

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

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

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

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

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

Appendix 1

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

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

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

Appendix 2

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

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

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

Appendix 3

Weakest Medical Malpractice Insurers

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

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

Source: Weiss Ratings, Inc.

Appendix 4

Other Studies and Position Statements published by Participants in this Debate

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

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

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

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

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

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

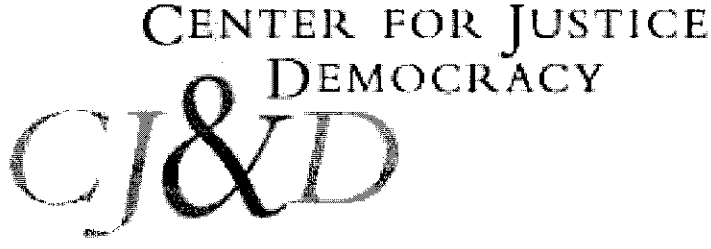
"President's Medical Malpractice Plan Based on Biased, Inaccurate Information; CFA Identifies Insurer Practices as Cause of Soaring Rates." Consumer Federation of America. July 31, 2002. http://www.consumerfed.org/073102medmalrelease.html.

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

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

PREMIUM DECEIT

THE FAILURE OF "TORT REFORM" TO CUT INSURANCE PRICES



By J. Robert Hunter and Joanne Doroshow

MTLA

Thanks to Joan Mulhern for her assistance, and to the many individuals around the country who helped ensure the accuracy of the report's legal research.

PREMIUM DECEIT --The Failure of "Tort Reform" to Cut Insurance Prices
By J. Robert Hunter and Joanne Doroshow

Copyright © 1999, 2002 by Center for Justice & Democracy.

All rights reserved. No part of this report may be reproduced or transmitted in any form or by any means, electronic or mechanical, including photocopying, recording or by an information or storage and retrieval system, without written permission of the authors.

Printed in the United States.

Center for Justice & Democracy (CJ&D) is a non-profit, national consumer organization dedicated to raising public awareness about the importance of our civil justice system.

Additional copies of this report may be obtained by sending a check or money order for $100* made payable to CJ&D, to:

Center for Justice & Democracy
P.O. Box 3326
Church Street Station
New York, NY 10008-3326

*Lower rates are available for non-profit groups and for bulk copies. Contact CJ&D for more information: 212/267-2801 or e-mail info@centerjd.org.

PREMIUM DECEIT

THE FAILURE OF "TORT REFORM" TO CUT INSURANCE PRICES

EXECUTIVE SUMMARY

From the mid-1980s until today, the nation's largest businesses have been advancing a legislative agenda to limit their liability for causing injuries. One of the principal arguments on which they rely is that laws that make it more difficult for injured people to go to court (i.e., "tort reform") will reduce insurance rates. This report analyzes these claims, and concludes they are invalid.

The "tort reform" movement largely originated in the mid-1980's while the nation was suffering through a severe "liability insurance crisis."[1] Small businesses, doctors, non-profit groups and others were hit with dramatic increases in insurance premiums, reduced coverage and arbitrary policy cancellations. The situation received extensive media attention, such as *Time Magazine's* 1986 cover story entitled, "Sorry, Your Policy is Cancelled."[2]

The insurance industry and other large corporations blamed the crisis on the legal system and lobbied extensively for what they called "tort reform" – laws that restrict the rights of injured consumers to sue and obtain compensation from corporate lawbreakers and other wrongdoers. They claimed that enactment of "tort reform" would cause insurance rates to stabilize and even fall.

Great pressure was brought to bear on state legislatures around the country to restrict the rights of innocent victims to recover for their injuries and to hold wrongdoers accountable in court. Many states succumbed to this pressure and passed "tort reforms." Moreover, states have continued to adopt these laws. As recently as the spring of 1999, Florida passed an extensive "tort reform" package. And some New York lawmakers are considering a similarly broad proposal.

This study – the most extensive review of insurance rate activity in the wake of the liability insurance crisis ever undertaken – was designed to test the impact on liability

---

[1] On January 17, 1986, a number of business, professional and insurance trade organizations announced the formation of the American Tort Reform Association (ATRA).

[2] George J. Church., "Sorry, Your Policy Is Canceled," *Time Magazine,* March 24, 1986.

insurance rates of "tort reforms," specifically those that were passed by state legislators (or voters by ballot initiative) in reaction to the liability insurance crisis of the mid-1980s, and in the years since.

We obtained data on insurance rate and loss cost movement in every state from 1985 through 1998.[3] We then segregated the states into three categories: states that enacted the fewest number of tort law changes over the period; states that passed a mid-range level of tort law limits; and states that enacted the most "tort reform."

The hypothesis we tested was simple: if tort law limits succeed in reducing insurance costs for consumers of insurance, that should be evident in the trends of insurance costs. As tort law limits get more severe, the trends in rates and underlying loss costs should be less.

We tested this hypothesis for the lines of insurance subject to general tort reform and to product liability and medical malpractice separately, since states often enact separate tort law restrictions to be applied just in those areas.

We found that the trends in rates/loss costs do not support the hypothesis that "tort reform" has succeeded in holding down insurance costs or rates. Despite what "tort reform" proponents promised lawmakers, tort law limits enacted since the liability insurance crisis of the mid-1980s have not lowered insurance rates in the ensuing years. States with little or no tort law restrictions have experienced the same level of insurance rates as those states that enacted severe restrictions on victims' rights.

The "liability insurance crisis" of the mid-1980s was ultimately found to be caused not by legal system excesses but by the economic cycle of the insurance industry. Given large rate increases and cut backs in coverage, the insurance cycle soon turned again and prices began to fall. The nation has enjoyed a relatively "soft" insurance market for over a decade now – with rates of liability insurance not only stable but down.

Just as the liability insurance crisis was found to be driven by the insurance underwriting cycle and not a tort law cost explosion as many insurance companies and others had claimed, the "tort reform" remedy pushed by these advocates failed. As the findings of this report confirm, legal system restrictions are based upon a false predicate. "Tort reforms" do not produce lower insurance costs or rates.

---

[3] "Loss cost" is the term for the portion of each premium dollar taken in, that insurance companies use to pay for claims and for the adjustment of claims. Insurers use other parts of the premium dollar to pay for: their profit, commissions, other acquisition expenses, general expenses and taxes. Loss costs represent the largest part of the premium dollar for most lines of insurance.

BACKGROUND

The "Liability Insurance Crisis" of the Mid-1980s and its Progeny

From 1985 through the late 1980s, manufacturers, municipalities, doctors, nurse-midwives, day-care centers, non-profit groups and many other commercial customers of liability insurance, found themselves in the midst of a "crisis." Insurance rates were skyrocketing, up 300 percent or more for some. Many could not find coverage at any price.

Insurance companies said that their costs were being driven up by a so-called "explosion" in litigation, claiming "frivolous lawsuits" and "out of control" juries were suddenly forcing insurers to make insurance unaffordable and sometimes unavailable. They told state legislatures around the country that the only way to ease this crisis was to limit "tort" or liability laws, to make it more difficult for sick and injured consumers to sue and be compensated by wrongdoers in court (also known as "tort reform").

In 1986 alone – the year of the American Tort Reform Association's founding -- 41 states passed legislation to limit the liability of wrongdoers, restrict the amount of monetary damages injured consumers could receive in court, or make it more difficult for the injured to obtain attorneys to represent them against insurance companies. In a few states, legislatures enacted across-the-board tort law limits, overturning years of common law that for generations had afforded harmed citizens the right to challenge corporate wrongdoing in court.

For the most part, these new "tort limits" have remained on the books. Moreover, in every year since, states have enacted additional "tort reforms," based on the same rationale first advanced in the mid-1980s -- that restricting victims' rights will lead to more affordable liability insurance rates. (See Appendix A for list of "tort reforms" enacted in each state since 1985.)

But what ultimately proved to be the true cause of the "liability insurance crisis" of the mid-1980s was not the legal system at all. Study after study that examined the property/casualty insurance industry found that the "insurance crisis" was actually a self-inflicted phenomenon caused by the mismanaged underwriting practices of the industry itself.

The insurance industry's profits and underwriting practices are cyclical, often characterized by sharp ups and downs. In fact, these underwriting practices and the insurance cycle caused a similar, less severe "insurance crisis" in the mid-1970s. During years of high interest rates and/or excellent insurer profits, insurance companies engage in fierce competition for premiums dollars to invest for maximum return. Insurers lower prices and insure very poor risks just to get the premium dollars. In the mid-1980s, the cycle's effects were exacerbated by a particularly exaggerated underwriting response to

the high interest rates of the early 1980s, characterized by such risky underwriting as insuring the MGM Grand Hotel months *after it burned down in a fire.*[4]

By 1985 when interest rates had dropped and investment income had decreased accordingly, the industry responded by sharply increasing premiums and reducing availability of coverage, creating a "liability insurance crisis."

As *Business Week* magazine explained a January, 1987 editorial:

> Even while the industry was blaming its troubles on the tort system, many experts pointed out that its problems were largely self-made. In previous years the industry had slashed prices competitively to the point that it incurred enormous losses. That, rather than excessive jury awards, explained most of the industry's financial difficulties.[5]

The Ad Hoc Insurance Committee of the National Association of Attorneys General concluded after studying the "crisis" in 1986:

> The facts do not bear out the allegations of an "explosion" in litigation or in claim size, nor do they bear out the allegations of a financial disaster suffered by property/casualty insurers today. They finally do not support any correlation between the current crisis in availability and affordability of insurance and such a litigation "explosion." Instead, the available data indicate that the causes of, and therefore solutions to, the current crisis lie with the insurance industry itself.[6]

State commissions in New Mexico, Michigan and Pennsylvania reached similar conclusions.[7] Even the insurance industry admitted this internally. In 1986, Maurice R. Greenberg, President and Chief Executive Officer of American International Group, Inc., one of the country's leading property/casualty companies, told an insurance audience in Boston that the industry's problems were due to price cuts taken "to the point of absurdity" in the early 1980s. Had it not been for these cuts, Greenberg said, there would not be 'all this hullabaloo' about the tort system."[8]

But to the public and to lawmakers, insurers told a different story. In fact, coming out of their bottom year of 1984, insurance companies began a "massive effort to market

---

[4] One actuary at this time was quoted as saying "we don't need premiums anymore," relying instead on tax credits coupled with high interest rates.

[5] "What Insurance Crisis?," *Business Week,* January 12, 1987, p. 154.

[6] Francis X. Bellotti, Attorney General of Massachusetts, et al., *Analysis of the Causes of the Current Crisis of Unavailability and Unaffordability of Liability Insurance* (Boston, Mass.: Ad Hoc Insurance Committee of the National Association of Attorneys General, May, 1986).

[7] See, e.g., New Mexico State Legislature, *Report of the Interim Legislative Workmen's Compensation Comm. on Liability Insurance and Tort Reform,* November 12, 1986; Michigan House of Representatives, *Study of the Profitability of Commercial Liability Insurance,* November 10, 1986; Insurance Comm. Pennsylvania House of Representatives, *Liability Insurance Crisis in Pennsylvania,* September 29, 1986.

[8] Greewald, "Insurers Must Share Blame: AIG Head," *Business Insurance,* March 31 1986, p. 3.

the idea that there is something wrong with the civil justice system."[9] The goal, in the words of one of the industry's leading spokespersons, GEICO's chairman John J. Byrne, was "to withdraw [from the market] and let the pressure for reform build in the courts and in the state legislatures."[10] Evidence gathered by over a dozen state attorneys general for an antitrust class action filed in 1988, and settled in 1995, found that a number of insurance companies actually conspired to create this insurance crisis by restricting coverage to commercial customers and raising prices, creating an atmosphere intended to coax states into enacting "tort reform."[11]

To support this effort, the Insurance Information Institute purchased $6.5 million worth of print and television ads in 1986, designed to reach 90 percent of all U.S. adults, in order "to change the widely held perception that there is an 'insurance crisis' to a perception of a 'lawsuit crisis.'"[12] The ads targeted groups that were having difficulty obtaining affordable insurance. Headlines read, *The Lawsuit Crisis is Bad for Babies, The Lawsuit Crisis is Penalizing School Sports* and *Even Clergy Can't Escape the Lawsuit Crisis,* and they appeared in *Readers' Digest, Time* and *Newsweek*, as well as in Sunday magazine supplements.[13] In 1986, after Congressman John J. LaFalce (D-N.Y.) asked the Insurance Information Institute to submit information to Congress to back up the "clergy" ads, he stated:

> The information they gave us would lead us to conclude that there are only about a dozen of these religious malpractice cases pending throughout the country, and that the only one that has gone to trial was dismissed in favor of the defendant. In other words, ... at the time these ads were run, the insurance industry had not yet paid out one cent pursuant to any court judgment in any of these cases. Yet, they form an integral part of its national advertising campaign.[14]

Insurance companies and other insurance trade associations complemented the Insurance Information Institute campaign with their own ads. For example

- Johnson & Higgins ran several ads in 1985 and 1986. One that appeared in the *Wall Street Journal* on November 19, 1985, stated, "the mounting wave of losses, which last year cost insurers more than $116 for every $100 of premium taken in, has forced insurers to act defensively. Most have stopped offering pollution insurance entirely

---

[9] *National Underwriter,* December 21, 1984, p. 2.
[10] *Journal of Commerce,* June 18, 1985, p. 10A.
[11] *In re Insurance Antitrust Litigation*, MDL No. 767, No. C 88 1688 [CAL], N.D. Calif.); "Final Approval Given To Insurance Antitrust Settlement," *Mealey's Litigation Reports,* April 18, 1995.
[12] Herbert, "$6.5 Million In Ads Targets Lawsuit Crisis," *Journal of Commerce*, March 19, 1986, p. 1.
[13] *Ibid.*
[14] *The Liability Insurance Crisis, Hearings before the Subcomm. on Economic Stabilization of the Comm. on Banking, Finance and Urban Affairs*, House of Representatives, 99th Cong., 2d. Sess., Part 1, July 23, 1986, p. 2.

and have cut back on other vital liability coverages ... Nothing has done more to create this ominous situation than the field day plaintiffs are having in court."[15]

- Aetna ran a series of ads in 1987. One contained a pull-quote that read, "Somehow we've managed to create a [civil justice] system that makes good people behave badly." The ad blamed the civil justice system for the fact that "insurers, whose reasons for being in business is to pool risks so that they are affordable, start looking for reasons not to take risks."[16]
- A full-page ad in the September 11, 1987, *Sacramento Bee,* placed by the Association of California Insurance Companies, "invited the California Trial Lawyers Association to help put the brakes on insurance costs by supporting a cut in contingency fees and limiting non-economic damages from auto accidents."

State legislatures, regulators, and voters in ballot initiative states, were all told by business and insurance lobbyists (and their PR firms) that the way to bring down insurance rates was to make it more difficult for injured consumers to sue in court. For example,

- At a 1986 meeting of National Association of Insurance Commissioners, Iowa's commissioner, William D. Hager, remarked, "The insurance industry has argued for some time that insurance rates and availability are predicated upon the high costs associated with the expanding tort system. It should clearly follow, therefore, that insurance rates will decrease and the availability improve with the advent of legislative reforms of the tort system."[17]
- Iowa's Attorney General Tom Miller asserted in 1986, "reforms are needed to reduce tort liability in the state and consequently cut spiraling insurance rates."[18]
- A spokesman for the Texas Medical Association promised in 1986, "If significant tort reform is passed next year, there will be an immediate stabilization of premiums."[19]
- In its March, 1987 newsletter, the Association for California Tort Reform, announced, "[D]oes significant reform mean lower insurance premiums? Yes!"
- Ralph Gaines, Jr., a spokesman for the Alabama Civil Justice Reform Committee, said in 1987, "rigorous and meaningful tort reform will go a long way to reduce rates in insurance premiums."[20]
- In New York in 1986, just months after state lawmakers responded once to the "insurance crisis" by enacting major "tort reforms," Minority Leader Clarence D. Rappleyea (R-Norwich) called for even more changes -- complete elimination of joint and several liability and a $250,000 cap on "non-economic damages -- saying these measures were still needed "to ease the liability insurance crisis."[21]

---

[15] Stephen Daniels, "The Question of Jury Competence and the Politics of Civil Justice Reform: Symbols, Rhetoric, and Agenda-Building," 52 Law & Contemp. Prob. 261 (1989).
[16] *Ibid.*
[17] Kenneth Reich, "Insurers told rate cuts must precede more legal reform" *Los Angeles Times,* December 14, 1986.
[18] Scott Sonner, "Miller calls for liability reform", UPI, February 21, 1986.
[19] UPI, October 24, 1986.
[20] Dana Beyerle, "Civil liability law reform urged," UPI, April 7, 1987.
[21] "Tort Reform, Banks on NY Insurance Agenda", *Journal of Commerce,* January 22, 1987.

- To garner support for Florida's Amendment 10, the unsuccessful 1988 ballot initiative that would have capped noneconomic damages at $100,000, the Florida Medical Association argued that "the cap was a necessary tradeoff to stop spiraling insurance rates."[22]
- Doctors in Montana and their insurers believed in 1988, "if tort reform is enacted to make the system more predictable, insurance rates will stabilize or drop."[23]
- In a November 7, 1988, editorial entitled "Prepare for the backlash," the *National Underwriter,* an insurance trade publication, bluntly conceded, "Let's face it. The only reason tort reform was granted in many states is because people accepted our argument that it was needed to control soaring insurance rates."

However, notwithstanding this well-orchestrated public relations and lobbying campaign, there was a "virtual absence of empirical evidence that tort reform [would] indeed lower liability insurance rates or expand the insurance's availability," as one business trade publication put it."[24] What's more, when they were pushed hard by legislators to provide guarantees that rates would drop, they could not. And their subsequent rate filings with insurance departments confirmed this. For example,

- In 1986, lobbyist Peter G. Strauss of the Alliance of American Insurers, testified that "liability insurance rates would go down" if the New Jersey legislature enacted a cap on damages, repealed the collateral source rule and eliminated joint and several liability. However, "he said he could not say how much rates would drop." And, under questioning from New Jersey Senate President John F. Russo (D-Ocean County), "he said that he knew of no state where rates had declined as a result of such 'caps' or other revisions in the civil justice system."[25]
- In 1986, Washington State enacted what was considered at the time "one of the most comprehensive [tort] reform bills yet." Before it passed, Ted E. Linham, president of the Washington State Physicians Insurance Association, "testified in the state legislature that the new law would reduce premiums charged by the association, which is a mutual company, by 25% to 30% within 18 months after the legislation takes effect Aug. 1." However, after the law passed, the company asked for a rate *hike*, and state regulators began "looking for an explanation of why the insurer wants a premium hike after the industry was successful in getting tort reform."[26]
- Following enactment of extensive "tort reforms" in Florida in 1986, Aetna and St. Paul Marine Insurance Company filed rate documents notifying Florida's insurance commissioner that even these extensive tort changes would not reduce rates. Filings made in 1986 by 104 insurers licensed in Florida showed that out of 277 filings, 175,

---

[22] Stephen Koff, "Voters deal hard blow to limits on liability," *St. Petersburg Times,* November 9, 1988.
[23] Mike Dinnison, "In rural areas, doctors are delivering sad message to mothers-to-be," *Los Angeles Times,* May 1, 1988.
[24] Editorial, Crain's *Chicago Business,* June 9, 1986.
[25] Carolyn Acker, "Russo: Pending legislation won't ease insurance rates," *Philadelphia Inquirer,* September 5, 1986; Vincent R. Zarate, "$500,000 liability lid proposed by Russo," *Star-Ledger,* Sept. 5, 1986.
[26] "State hires outside firm to look at liability rate request," *UPI,* December 4, 1986. See also, "Tort reform legislation: Did state get 'suckered,'" *The Seattle Times,* July 1, 1986, p. 1.

or 63 percent showed no savings from "tort reform" while none showed savings of more than 10 percent.[27]

- In 1986, Connecticut enacted major "tort reforms" to "bring insurance premiums down by setting ceilings and other restrictions on liability." But by 1987, one state lawmaker was noting, "the insurance industry now says those measures will have no effect on insurance rates. We have been disappointed by the response of the insurance industry. The reforms we passed should have led to rate reductions because we made it more difficult to recover, or set limits on recovery. But this hasn't happened."[28]

Eventually, a few years after the mid-1980s insurance crisis, the insurance cycle flattened out, rates stabilized and availability improved everywhere. This had nothing to do with tort law restrictions enacted in particular states, but rather to modulations in the insurance cycle everywhere. In 1991, for example, Washington's insurance commissioner Dick Marquardt concluded in a report that it was "impossible to attribute stable insurance rates to tort-law changes or the damages cap," since rates also improved in states that did not pass tort reform.[29] The reason, of course, is that "tort reform" is based on an untrue premise: that the legal system, rather than the underwriting practices of the insurance industry, is responsible for gyrations in the cost and availability of insurance.

Despite this evidence, states have continued to enact sometimes drastic limitations on the rights of severely injured people, in the hopes that insurance rates still might drop. For example, Illinois passed such severe restrictions in 1995 (although the law was largely declared unconstitutional in 1997[30]) in part, "to protect the availability of affordable liability insurance.[31] As recently as the spring of 1999, Florida passed an extensive "tort reform" package including caps on punitive damages, severe limits on joint and several liability and a statute of repose in products liability cases. Florida's business lobbyists frequently cited the insurance argument before the bill finally passed.[32] And some New York lawmakers are now considering a similarly broad proposal, being pushed heavily by a coalition of insurance companies and large business interests who are making comparable claims about liability insurance rates.[33]

---

[27] "'Tort Reform' a Fraud, Insurers Admit," and "Tort Reform Will Not Reduce Insurance Rates, Say 100+ Florida Insurers," National Insurance Consumer Organization (1986).

[28] "Insurers Warn," UPI, March 9, 1987.

[29] "Health care Reform – Bush's insurance cap plan a proven failure", *The Seattle Times,* May 16, 1991.

[30] *Best v. Taylor Machine Works,* 689 N.E. 2d 1057 (1997)

[31] Among the legislature's "findings" in the Illinois 1995 Tort Reform Act were: "drastic restrictions in coverage accompanied by vastly increased premiums have become permanent realities for many products and services ... [It] is the purpose of this Act to modify and improve the civil justice system in order to ... [p]rotect the availability of affordable liability insurance."

[32] Jon Shebel of Associated Industries said severe restrictions on attorneys' fees would "lower liability insurance rates." William March, "Tort Reform Weighs In Race For District 58," *The Tampa Tribune,* September 19, 1997. Lee Hinkle, a lobbyist for the Florida Chamber of Commerce, said that with tort reform, "families would see ... savings in the form of ... smaller insurance premiums." Gordon Russell, "Business Sees A Victory After Tort Reform Law Changes Pass," *Sarasota Herald-Tribune,* May 1, 1998.

[33] In its 1998 report *An Accident and a Dream,* the Public Policy Institute – the research arm of the Business Council of New York State which is a major force behind "tort reform" legislation under

This report, the first comprehensive empirical study of "tort reform's" impact on insurance costs and rates since 1985, shows that legislative attempts to reduce insurance rates by taking away the rights of the most seriously injured in our society, has been and continues to be a failed public policy.

consideration in New York -- says, "everyone pays for [large] awards, through ...higher insurance premiums," and announced in a March 1998 press release that if New York enacted certain tort reforms, "New Yorkers would save roughly $800 million a year, or roughly 6 percent, in liability premiums and self-insurance payments."

METHODOLOGY

We purchased from the Insurance Services Office (ISO) the Chief Executive Circular Letters showing the state-by-state price or advisory loss cost level activity for the years 1985 through 1998.[34] These letters show, for each line of insurance for which ISO performs statistical and actuarial analysis, the changes recommended by ISO to its insurance company members, subscribers and other customers, after filing and action by the state insurance regulators.

In the early years of this review, ISO was recommending final rates to be charged by insurers. The Circular Letters were called "Price Activities" from 1985 until 1990 when it was changed to "Loss Cost/Rate Level Activity." In 1994 the name was changed again, to "Loss Cost Level Activity," a title the Circular Letters still use. [35] These later names reflect the changing role of ISO as it increasingly stopped recommending full, final prices and, instead, recommended only the loss portion of the rate (i.e. the expected claims costs, also known as "loss costs").

ISO has the largest database of audited, unit transaction data of any entity in the United States. "Unit transaction" means that the data are generated each time a transaction occurs (such as a policy being bought or a claim filed or paid). This allows for a paper trail back to actual records if ISO audits determine that an insurer is filing "bad" data. ISO audits these data and requests corrections as necessary based upon that review.

ISO data therefore represent the most reliable and largest database for determining trends in insurance costs as measured either by final rates being suggested by ISO in the 1980s or by the trends in loss costs in more recent years.

From these ISO Circular Letters, a 14-year (1985 through 1998) database was constructed for lines of insurance that had a liability component. The database shows the year-by-year change ISO filed with each state and got approved or otherwise went into effect, for each line of insurance. For example, the data for a state for a specific line of insurance might show that rates/loss costs went up by 5.4% in a specific year. We recorded this change along with changes from each year for the years 1985 to 1998 into

[34] "Loss cost" is the term for the portion of each premium dollar taken in, that insurance companies use to pay for claims and for the adjustment of claims. Insurers use other parts of the premium dollar to pay for: their profit, commissions, other acquisition expenses, general expenses and taxes. Loss costs represent the largest part of the premium dollar for most lines of insurance.

[35] The dates of the Chief Executive Circulars relied upon in this study are: January 6, 1986, January 6, 1987, January 5, 1998, January 3, 1989, January 4, 1990, January 4, 1991, January 6, 1992, January 7, 1993, January 7, 1994, January 6, 1995, January 5, 1996, January 6, 1997, January 8, 1998 and January 8, 1999.

the database for each state. Ultimately we combined the changes to obtain the total change for the entire period 1985 to 1998.[36]

The lines of insurance covered by the database we created are: Personal Auto Basic Limits Liability[37], Commercial Auto Bodily Injury and Property Damage Liability, Personal Combined Total Limits Liability, Owner's, Landlord's and Tenants (OL&T) Liability, Manufacturer's and Contractor's (M&C) Combined Total Limits Liability, Special Multi-Peril, Hospital Professional Liability, Physicians', Surgeons' and Dentists' (PS&D) Professional Liability, and Product Combined Total Limits Liability.

In order to measure the impact on insurance costs of tort law limits, we placed the states into three Categories (1, 2 and 3), based on the following criteria:

We evaluated the major tort law limits passed by state legislatures or by ballot initiative from 1985 through 1997. Decisions as to what constituted a "major tort law limit" were based on materials compiled by the American Tort Reform Association (ATRA) and the Association of Trial Lawyers of America (ATLA), additional legal research and consultation with lawyers or lobbyists in every state. We divided these laws into three separate sections for evaluation: limits that apply across the board in tort cases, limits that apply in medical malpractice cases, and limits that affect product liability actions. This is to ensure that we evaluate the impact of tort law changes only on those lines of insurance that are relevant.

We defined as a "major tort law limit" any provision enacted by a state legislature that ATRA and ATLA define as a "tort reform," with certain exceptions explained below. Included are: caps on damages (economic, non-economic and/or punitive damages), modifications to joint and several liability, modifications to the collateral source rule, structured settlements (except if optional for plaintiffs), limits on prejudgment interest, limits on contingency fees for plaintiffs' attorneys, new product liability defenses (except if codifying the common law), and statutes of repose for products. (See Appendix B for descriptions of these terms.) Certain unique state statutes are also included, such as Virginia's Birth-Related Neurological Injury Compensation Act, an injury compensation fund for catastrophically injured newborns that precludes non-economic and punitive damages.

Not included either because they varied widely for different causes of action, were part of the common law or were court imposed (this study is only evaluating the impact of legislative or voter responses), were limited to narrow causes of action, or varied so widely from state to state as to make them impossible to compare, were:

---

[36] We did this by adding the change for each year to unity (e.g. 5.4% added to unity create a factor of 1.054 for that year. We multiplied the changes together to get a factor for the entire 1985 to 1998 period and subtracted unity to obtain the 14 year percentage change.

[37] Our original database included personal auto liability. We did not use it, however, both because of widely differing auto insurance systems between states and because the study focused on tort law changes other than auto changes, including no-fault, which were not related to the liability insurance crisis of the mid-1980s.

statutes of limitations, punitive damages standards (many are court imposed), immunity for specific industries, governments or groups, arbitration rules, or wrongful death statutes. In addition, we did not consider auto insurance laws in this study. This is both because of widely varying state auto insurance systems (for example, a number of states have no-fault systems with varying thresholds and benefit levels). But also, changes in auto insurance systems, while sometimes paralleling the major, national corporate drive for "tort reform" which gained momentum the mid-1980s, is largely separate from this movement.

Sometimes, as with joint and several liability, the legislature decided to modify the law in some respect. Other times, it decided to abolish the doctrine altogether. Also, caps on damages vary in size. No subjective weight was attached to any of these decisions, or to the reforms themselves. The assumption was that whatever was enacted was whatever the legislature was convinced was necessary to bring down insurance rates, among other things, in that state at that time. The longer a tort limit has been in effect, the more weight has been attached to its expected impact on costs over time. In other words, more weight is given to a punitive damages cap enacted in 1986 than to one enacted in 1991, and even more weight is attached to it than a cap passed in 1996. If a law was struck down as unconstitutional, appropriate weight is given depending on how many years the law was in effect.

Since this study is evaluating only legislative actions since 1985, no weight was attached to tort limits enacted prior to those years. Therefore, this breakdown is not necessarily a good measure of the current severity of a state's tort laws limits. For example, some states, like California and Delaware, enacted significant medical malpractice limits before 1985, which have had serious impact on victims' rights in these states. However, they are not part of the legislative response we are examining here.

Once the final list of tort law limits was determined, each provision was weighted based on the number of years in effect. Each listing (general, medical malpractice and product liability) was then divided into three evenly divided categories of 17 (50 states plus the District of Columbia). Category 1 represents the states with the fewest tort limits passed over time, Category 3 the most. These categories are relative. Therefore, a state may have enacted a number of product liability limits during these years, yet may not place in Category 3 because other states have done more.

The state law breakdowns are listed in Appendix A.

For our analysis, we grouped several lines of insurance into a "General Tort" group. This group includes Commercial Auto Basic Limits Liability, Personal Liability, OL&T Liability, M&C Liability and Special Multi-Peril. We combined these data on an overall basis, using premium as weights, to determine the effectiveness of tort reform on insurance rates.[38]

[38] The use of premium as weights is a standard actuarial technique for combining data. Use of simple averages would distort the results in unknown ways. This is the most accurate way to combine these data.

We reviewed Product Liability separately since law changes impacting product liability often were separate from or in addition to general tort law changes.

We reviewed the combination of Hospital Professional and PS&D Professional Liability Insurance and termed it "Medical Malpractice Insurance." Similar to product liability, law changes impacting medical malpractice liability often were separate from or in addition to general tort law changes.

The hypothesis underlying our analysis is simple: if tort law limits succeed in reducing insurance costs to consumers of insurance, that should be evident in the ISO trends in costs measured by rate and loss cost changes proposed by ISO to the states. Indeed, as the tort law limits get more severe, the ISO changes should be lower. The analysis, discussed below, tests this hypothesis with the facts we assembled.

Appendix C contains three exhibits showing the overall changes in prices by line of insurance. They are General Tort (Exhibit 1), Products Liability (Exhibit 2) and Medical Malpractice (Exhibit 3).

Exhibit 1 --General Tort, shows the 14 year (1985 to 1998) rate/loss cost change ISO achieved for its insurer members for each of the general tort lines of insurance. The exhibit ranks the states by the ascending size of rate/loss cost change over the 1985 to 1998 period. The exhibit is coded by severity of tort law change (1 for the least severe change, 2 for the mid-range change and 3 for the most severe change states).

In order to combine the tort lines to obtain an overall change for general tort, the changes in rates/loss costs are weighted by the 1997 premiums for each line of insurance based on data from the National Association of Insurance Commissioners (NAIC).[39] Data on premiums for M&C and OL&T are not separately available, but data for "Other Liability" is available. We assumed that OL&T and M&C each represented 50% of Other Liability premium. We also estimated the premiums for personal liability at 5% of the state's personal auto liability premium.

Exhibit 2 -- Products Liability, shows the products liability rate/loss cost changes from 1985 to 1998 ranked by the ascending size of rate/loss cost change over the 1985 to 1998 period. No weightings are necessary here but we included the earned premiums from NAIC for analysis purposes, which will be discussed in the analysis section of this report. The same coding used in the General Tort Lines exhibit is applied here, but the categories are based, as indicated earlier, specifically on Product Liability law changes.

Exhibit 3 -- Medical Malpractice, shows the rate/loss cost changes from 1985 to 1998 ranked by the ascending size of rate/loss cost change over the 1985 to 1998 period. We averaged the Hospital Professional Liability rate/loss cost changes and the Physician, Surgeon and Dentist Liability rate/loss cost change to estimate the overall medical

---

[39] *Report on Profitability By Line By State, 1997,* National Association of Insurance Commissioners. Also see previous footnote for an explanation of why weighting by premiums increases the accuracy of the results.

malpractice changes. No other weightings are necessary but we included the earned premiums from NAIC for analysis purposes, which will be discussed in the analysis section of this report. The same coding used in the General Tort Lines exhibit is applied here, but the categories are based, as indicated earlier, specifically on Medical Malpractice law changes.

FINDINGS

General Tort

A visual inspection of Exhibit 1 reveals that there is no apparent significant difference between levels of tort law change and overall rate/loss cost impact. In other words, tort reform severity does not appear to be a predictor of rate/loss cost change.

We undertook to test this visual conclusion by weighting the rate/loss cost changes by state on the earned premiums for each of the three tort law severity categories.[40] This produced the following results.

TABLE 1

State Tort Law Change Severity	Weighted 14 Year Rate/ Loss Cost Change	Annualized Loss Cost Change[41]
1	+45.6%[42]	+2.9%[43]
2	+49.1	+3.1
3	+48.8	+3.1

This result indicates that there is no significant difference in insurance rates from the adoption of tort reform for the General Tort category. Indeed, the three categories of tort law change have no impact on rates/loss costs. That is, the underlying costs, which ultimately drive insurance prices, are not impacted by tort law changes of the type adopted in this nation since the liability insurance crisis of the mid-1980s.

Product Liability

A visual inspection of Exhibit 2 reveals that there is no apparent significant difference between levels of tort law change and overall rate/loss cost impact for product liability. In other words, tort reform severity does not appear to be a predictor of rate/loss cost change.

We undertook to test this visual conclusion by weighting the rate/loss cost changes by state on the earned premiums for each of the three tort law severity categories. This produced the following results.

---

[40] Weighting by premium is the proper actuarial method for combining the rate changes. This is because the rate changes are applied to rates which directly impact premiums.

[41] This result, raised to the 13th power (representing the change from 1985 to 1998, equals the second column).

[42] In other words, over the period 1985 to 1998, the premiums in the states with the least tort law changes rose by 45.6%.

[43] The 45.6% change over the period 1985 to 1998 represents a change of 2.9% per year for the period.

TABLE 2

State Tort Law Change Severity	Weighted 14 Year Rate/ Loss Cost Change	Annualized Loss Cost Change[44]
1	+80.4%	+4.6%
2	+52.0	+3.3
3	+74.8	+4.4

With these mixed results it is difficult to see any clear difference in insurance rates from the adoption of tort reform for the Product Liability category. That is, the underlying costs, which ultimately drive insurance prices, appear to be impacted by modest tort law changes but not by severe changes. This is not a logical result. The only reasonable conclusion is that no clear evidence of tort law change impacting insurance prices is determinable from these data.

MEDICAL MALPRACTICE

A visual inspection of Exhibit 3 reveals that there is an apparent difference between levels of tort law change and overall rate/loss cost impact. In other words, based on this visual inspection, tort reform severity may be a predictor of rate/loss cost change.

We undertook to test this visual conclusion by weighting the rate/loss cost changes by state on the earned premiums for each of the three tort law severity categories. This produced the following results.

TABLE 3

State Tort Law Change Severity	Weighted 14 Year Rate/ Loss Cost Change	Annualized Loss Cost Change[45]
1	+179.5%	+8.2%
2	+214.5	+9.2
3	+120.2	+6.3

This result indicates that there is a modest rise in insurance rates/loss costs from the adoption of mid-range tort reforms for the Medical Malpractice category. That is, the underlying costs, which ultimately drive insurance prices, are impacted *upwardly* by mid-range medical malpractice tort law changes of the type adopted in this nation since the liability insurance crisis of the mid-1980s. This is counter-intuitive. While there does

[44] This result, raised to the 13th power (representing the change from 1985 to 1998, equals the second column).

[45] This result, raised to the 13th power (representing the change from 1985 to 1998, equals the second column).

appear to be a reduction in rates/loss costs from severe tort law changes in medical malpractice, compared to the changes in categories 1 and 2, the mixed results confuse any conclusion. One reasonable conclusion is that no clear evidence of tort law change impacting insurance prices is determinable from these data.

IMPLICATIONS OF FINDINGS

If the hypothesis is correct – that enactment of tort law limits (or "tort reform") since 1985 has reduced insurance rates/loss costs for consumers of insurance – then the following should be true: states that enacted little or no "tort reform" since the mid-1980s should be experiencing the highest insurance rate/loss cost increases; states with moderate "tort reform" should see lower rate/loss cost increases; and states that enacted major tort law limits should realize the lowest increases in rates/loss costs.

The data do not support this hypothesis.

Indeed, there is no evidence that general, across-the-board "tort reform" (or product liability "tort reforms") has lowered insurance rates/loss costs. The impact of tort limits enacted in medical malpractice cases is inconsistent and inconclusive, with apparently lower rate/loss cost increases for severe law changes over time but an increase in rates/loss costs for moderate law changes compared to little or no law changes.

The same mixed picture emerges when a review of similar states is undertaken. For example, consider the following data from similar industrial states:

TABLE 4

STATE	TORT LAW CHANGE RANKING	GEN. TORT 85-98 CHANGE	PRODUCTS 85-98 CHANGE	MED. MAL. 85-98 CHANGE
Illinois	2	+51.9%-	10.8%	+55.2%
Michigan	3	+13.4	+79.3	+154.9
Missouri	2[46]	+5.1	+62.7	+156.8
Ohio	3[47]	+11.5	+88.0	+282.8
Pennsylvania	1	+28.3	+109.8	+264.8
Wisconsin	1[48]	+19.2	+84.2	+58.8

It is difficult to discern any pattern of rate/loss cost effect based upon the degree of tort law change from these similar states. In General Tort, the highest and lowest changes are from states with moderate tort law change. In Products, the highest change is in a low tort law change state but the least change is in a moderate tort law change state.

[46] Missouri ranks in Category 3 for medical malpractice tort law changes.
[47] Ohio ranks in Category 2 for medical malpractice tort law changes.
[48] Wisconsin ranks in Category 2 for medical malpractice tort law changes.

In Medical Malpractice, the lowest rate/loss cost changes are in category 2 and 1 states, the highest in a category 2 state.

It is also interesting to note that there are states with little or no change with low rate/loss cost changes and states with severe changes with large increases in rate/loss cost. In other words, some states that have resisted any "tort reform" since 1985 have experienced low increases in insurance rates/loss costs relative to the national trends, and some states that enacted major "tort reform" packages have seen very high rate/loss cost increases relative to the national trends.

For instance, in General Tort, Massachusetts had no tort law changes in the period of study but had an increase in rate/loss cost of only25.9% for the 14 year period, averaging 1.8% a year, well below general inflation. Massachusetts enjoyed the 10th lowest increase in the nation.

New Jersey, on the other hand, adopted severe tort law changes such as joint and several liability, collateral source and a cap on punitive damages. Yet New Jersey had a rate/loss cost increase of 82.7% (or 4.7% a year, 2.6 times the rate of change in Massachusetts). New Jersey suffered the eighth highest cost increase in the nation during the 1985 to 1998 period.[49]

While it is beyond the scope of this report to determine what is responsible for these unexpected findings, it is clear that factors other than changes in the tort law are the cause. Further research is required to understand what drives these rate/loss costs since tort law restrictions are not it.

[49] Similar findings can be cited in Product Liability and Medical Malpractice. In Product Liability, Kentucky and Massachusetts have little tort reform . Kentucky's rates/loss costs declined for the period and Massachusetts (with no law changes) was the ninth lowest rate/loss cost change state in the nation. Four severe tort law change states (Alaska at #3, Idaho at #4, New Jersey at #5 and Florida at #9) were in the ten highest rate/loss cost change states for Product Liability. In Medical Malpractice, New Mexico with little tort law change was the ninth least rate/loss cost increase state while Idaho, with severe tort law changes, was 14th most costly in rate/loss cost increases.

CONCLUSION

To our knowledge, this study is the most comprehensive review of the impact of tort law changes on insurance rates/loss costs to date. The key finding is : the data do not support any conclusion that enactment of tort law limits since the liability insurance crisis of the mid-1980s has succeeded in reducing insurance costs to insurance consumers.

Just as the liability insurance crisis was ultimately found to be driven by the insurance underwriting cycle and not a tort law cost explosion as many insurance companies had claimed, the remedy pushed by the insurance companies failed. Laws that restrict the rights of injured consumers to go to court do not produce lower insurance costs or rates, and insurance companies that claim they do are severely misleading this country's lawmakers.

ABOUT THE AUTHORS

J. ROBERT HUNTER, an actuary, is currently the Director of Insurance for the Consumer Federation of America (CFA) He was formerly the Commissioner of Insurance for the State of Texas, the Federal Insurance Administrator under both Presidents Carter and Ford, and President and Founder of the National Insurance Consumer Organization.

As a consultant on public policy and actuarial issues for various government agencies, his clients have included the U.S. Department of Housing and Urban Development, the General Accounting Office, and the Environmental Protection Agency, as well as state governments including California, Florida, Georgia, Massachusetts, Maine, North Carolina, New Jersey, New York, Oklahoma, South Carolina and Texas. Other experience includes work in the private sector, including as Associate Actuary for the Mutual Insurance Advisory Association and Mutual Insurance Rating Bureau (now AIPSO), Actuarial Supervisor for the National Bureau of Casualty Underwriters (now ISO), and Underwriter, Atlantic Mutual and Centennial Insurance Companies.

His awards include the Award for Excellent Service for the Secretary of the Department of Housing and Urban Development (HUD), for work performed from 1971 to 1977. He is the author of numerous publications on insurance and related topics and has served as an Executive Committee member and advisor to the National Association of Insurance Commissioners (NAIC).

JOANNE DOROSHOW is the Executive Director of Center for Justice & Democracy (CJ&D). Joanne is an attorney who has worked on civil justice issues since 1986, when she first directed a project for Ralph Nader on liability and the insurance industry. In that capacity, she developed some of the first educational materials used to fight tort reform around the country. Joanne co-authored two major CJ&D reports: *Premium Deceit: The Failure of "Tort Reform" to Cut Insurance Prices*, and *The CALA Files: The Secret Campaign by Big Tobacco and Other Major Industries to Take Away Your Rights* (for which she won the 2000 Hoosier Freedom Award from the Indiana Trial Lawyers Association). She also edited *Lifesavers: CJ&D's Guide to Protect Us All*, and co-wrote several CJ&D White Papers. She also wrote *Goliath: Lloyd's Of London In The United States* (1988) and *Safeguarding Democracy: The Case For The Civil Jury* (1992).

Ms. Doroshow has extensive media experience as one of the producers of the 1992 Academy Award-winning documentary, *The Panama Deception,* and Coordinating Producer for TV Nation, the Emmy Award-winning humorous political magazine show. Her experience also includes lead counsel for TMI Alert, a community group working to block the restart of the Three Mile Island 1 nuclear reactor following the 1979 accident, and as director of the California-based Bhopal Justice Campaign in 1989 and 1990 created to win broad statewide support for the plight of the Bhopal, India gas disaster victims.

She was recently honored with one of two 1999 Public Interest Pioneer grants by the Stern Family Fund.

APPENDIX A

"TORT REFORMS" ENACTED IN STATES

General "Tort Reforms"

Alabama
Pre-1985: collateral source
87: punitive cap (but declared unconstitutional in 93)
87: collateral source (but declared unconstitutional in part in 96)

Alaska
86: cap, noneconomic
86: joint and several liability
86: collateral source rule
88: joint and several liability (ballot initiative)
97: cap, all damages
97: punitive cap
97: prejudgment interest

Arizona
87: joint and several (except hazardous waste, intent)
97: joint and several liability (hazardous waste exemption removed)

Arkansas

California
86: joint and several liability (ballot initiative)

Colorado
86: cap, noneconomic
86: joint and several liability
86: punitive cap
86: collateral source

Connecticut
86: collateral source
86: joint and several (i.e. proportional) liability
86: contingency fees

Delaware
Pre-1985: collateral source

District of Columbia
Pre-1985: collateral source

Florida
86: joint and several liability (except pollution, intent)
86: collateral source
86: contingency fees
86 : punitive cap

88: cap, noneconomic (but declared unconstitutional in 91)

Georgia
87: punitive cap
87: joint and several liability

Hawaii
86: cap, noneconomic (except products, asbestos, toxics, auto, aircraft , intent, some auto)
86: joint and several (except products, asbestos, toxics, auto, aircraft , intent, some auto)
86: collateral source (liens)

Idaho
87: cap, noneconomic
87: joint and several liability (except intent, hazardous waste and drugs and medical products)
87: structured settlements
90: collateral source

Illinois
86: collateral source
95: cap, noneconomic (but declared unconstitutional in 97)
95: joint and several liability (but declared unconstitutional in 97)
95: punitive cap (but declared unconstitutional in 97)

Indiana
Pre-1985: joint and several liability
86: collateral source
95: punitive cap

Iowa
Pre-1985: joint and several liability
86: structured settlements
87: collateral source
87: prejudgment interest
87: structured settlements
97: joint and several liability
97: prejudgment interest

Kansas
86: structured settlements (but declared unconstitutional in 88)
87: cap, noneconomic
87: punitive cap
88: collateral source (but declared unconstitutional in 93)

Kentucky
88: joint and several liability (but codified common law rule)
88: collateral source (but declared unconstitutional in 95)

Louisiana
Pre-1985: joint and several liability
87: joint and several liability
87: prejudgment interest
96: joint and several liability

Maine
88: prejudgment interest

Maryland
Pre-1985: collateral source
86: cap, noneconomic (but annual increases since 95)
86: structured settlements

Massachusetts

Michigan
86: collateral source
86: prejudgment interest
86: structured settlements
87: joint and several liability
95: joint and several liability

Minnesota
86: cap, noneconomic (but repealed in 90)
86: collateral source
86: prejudgment interest
88: joint and several liability

Mississippi
89: joint and several liability

Missouri
87: joint and several liability
87: collateral source

Montana:
87: joint and several liability (but declared unconstitutional in 94)
87: collateral source
95: structured settlements
97: joint and several liability

Nebraska
Pre-1985: collateral source
86: prejudgment interest (but improved prior standard)
92: joint and several liability (but improved prior standard)

Nevada
87: joint and several liability (except products, toxics, intent)
89: punitive cap

New Hampshire
86: cap noneconomic (but declared unconstitutional in 91)
86: punitives abolished
89: joint and several liability
95: prejudgment interest

New Jersey
Pre-1985: contingency fees
87: joint and several liability
87: collateral source
95: punitive cap
95: joint and several liability

New Mexico
87: joint and several liability (but codified common law)

New York
86: joint and several liability, (except toxics, intent, some products)
86: collateral source
86: structured settlements

North Carolina
95: punitive cap

North Dakota
87: joint and several liability (except products, intent)
87: collateral source
87: structured settlements
93: punitive cap

Ohio
87: joint and several liability
87: structured settlements
96: cap, noneconomic
96 : joint and several liability
96: punitive cap
96: collateral source
96: prejudgment interest

Oklahoma:
86: prejudgment interest
95: punitive cap

Oregon
87: cap, noneconomic
87: joint and several liability
87: collateral source
95: joint and several liability

Pennsylvania

Rhode Island
87: prejudgment interest

South Carolina

South Dakota
86: structured settlements
87: joint and several liability

Tennessee

Texas
87: joint and several liability (except environmental)
87: punitive cap
87: prejudgment interest
95: joint and several liability
95: punitive cap

Utah
86: joint and several liability

Vermont
Pre-85: joint and several liability

Virginia
87: punitive cap

Washington
Pre-1985: punitive cap
86: cap, all damages (but declared unconstitutional in 89)
86: joint and several liability (except environmental, some products)
86: structured settlements

West Virginia

Wisconsin
95: joint and several liability

Wyoming
86: joint and several liability

Products Liability "Tort Reforms"

Alabama
Pre-1985: collateral source
87: punitive cap (but declared unconstitutional in 93)
87: collateral source (but declared unconstitutional in part in 96)

Alaska
86: cap, noneconomic
86: joint and several liability
86: collateral source rule
88: joint and several liability (ballot initiative)
97: cap, all damages
97: punitive cap
97: prejudgment interest

Arizona
Pre-1985: products liability defenses; products statute of repose (but declared unconstitutional in 93)
89: products liability defenses
87: joint and several liability (except hazardous waste, intent)
97: joint and several liability (hazardous waste exemption removed)

Arkansas
Pre-1985: products liability defenses

California
86: joint and several liability (ballot initiative)
87: products liability defenses (inherently dangerous products) but tobacco cases exempt in 97

Colorado
86: cap, noneconomic
86: joint and several liability
86: punitive cap
86: products statute of repose
86: collateral source

Connecticut
Pre-1985: products liability punitive cap
86: collateral source
86: joint and several (i.e. proportional) liability
86: contingency fees

Delaware
Pre-1985: collateral source

District of Columbia
Pre-1985: collateral source

Florida
86: joint and several liability, (except pollution, intent)
86: collateral source
86: contingency fees
86 : punitive cap
88: cap, noneconomic (but declared unconstitutional in 91)

Georgia
Pre-1985: products statute of repose
87: punitive, one per product (but declared unconstitutional in 90))
87: joint and several liability
87: products liability defenses

Hawaii
86: collateral source (liens)

Idaho
Pre-1985: products statute of repose
87: cap, noneconomic
87: joint and several liability (except intent, hazardous waste and drugs and medical products)
87: structured settlements
90: collateral source

Illinois
86: collateral source
95: cap, noneconomic (but declared unconstitutional in 97)
95: joint and several liability (but declared unconstitutional in 97)
95: punitive cap (but declared unconstitutional in 97)
95: products statute of repose (but declared unconstitutional in 97)
95: products liability defenses (but declared unconstitutional in 97)

Indiana
Pre-1985: joint and several liability; products liability defenses
86: collateral source
95: punitive cap
95: products liability defenses
Iowa
Pre-1985: joint and several liability

86: structured settlements
86: products liability defenses
87: collateral source
87: prejudgment interest
87: structured settlements
97: joint and several liability
97: products statute of repose
97: prejudgment interest

Kansas
Pre-1985: products liability defenses; products statute of repose
86: structured settlements (but declared unconstitutional in 88)
86: products liability defenses
87: cap, noneconomic
87: punitive cap
88: collateral source (but declared unconstitutional in 93)

Kentucky
Pre-1985: products liability defenses; products statute of repose
88: joint and several liability (but codified common law rule)
88: collateral source (but declared unconstitutional in 95)

Louisiana
Pre-1985: joint and several liability
87: joint and several liability
87: prejudgment interest
88: products liability defenses
96: joint and several liability

Maine
88: prejudgment interest
96: products liability defense

Maryland
Pre-1985: collateral source
86: cap, noneconomic (but annual increases since 95)
86: structured settlements

Massachusetts

Michigan
86: collateral source
86: prejudgment interest
86: structured settlements
87: joint and several liability
95: products liability cap, noneconomic
95: joint and several liability
95: products liability defenses

Minnesota
86: cap, noneconomic (but repealed in 90)
86: collateral source
86: prejudgment interest
88: joint and several liability

Mississippi
89: joint and several liability
93: products liability defenses

Missouri
87: joint and several liability
87: collateral source
87: products liability defenses

Montana:
87: joint and several liability (but declared unconstitutional in 94)
87: collateral source
87: products liability defenses
95: structured settlements
97: joint and several liability

Nebraska
Pre-1985: collateral source; products statute of repose
86: prejudgment interest (but improved prior standard)
92: joint and several liability (but improved prior standard)

Nevada
89: punitive cap

New Hampshire
86: cap, noneconomic (but declared unconstitutional in 91)
86: punitives abolished
88: products liability defenses
89: joint and several liability
95: prejudgment interest

New Jersey
Pre-1985: contingency fee schedule
87: joint and several liability
87: collateral source
87: products liability defenses
95: punitive cap
95: joint and several liability
95: products liability defenses

New Mexico

New York
86: joint and several liability (except toxics, intent, some products)
86: collateral source
86: structured settlements

North Carolina
Pre-1985: products statute of repose
95: punitive cap
95: products liability defenses

North Dakota
Pre-1985: products liability defenses
87: products liability defenses
87: collateral source
87: structured settlements
93: punitive cap
93: products liability defenses
95: products liability defense
95: products statute of repose

Ohio
87: products liability defenses (but codified common law)
87: joint and several liability
87: structured settlements
96: cap, noneconomic
96: joint and several liability
96: punitive cap
96: collateral source
96: prejudgment interest
96: products liability defenses
96: products statute of repose

Oklahoma:
86: prejudgment interest
95: punitive cap

Oregon
Pre-1985: products statute of repose
87: cap, noneconomic
87: joint and several liability
87: collateral source
87: products liability defenses
95: joint and several liability
Pennsylvania
Rhode Island
87: prejudgment interest

South Carolina

South Dakota
Pre-1975: products liability defenses
86: structured settlements
87: joint and several liability
95: products liability defenses

Tennessee
Pre-1985: products liability defenses; products statute of repose

Texas
85: products liability defenses
87: joint and several liability (except environmental)
87: punitive cap
87: prejudgment interest
93: products liability defenses
93: products statute of repose
95: joint and several liability
95: punitive cap

Utah
86: joint and several liability
89: products liability defenses

Vermont:
Pre-85: joint and several liability

Virginia
87: punitive cap

Washington
Pre-1985: punitive cap; products statute of repose
86: cap, all damages (but declared unconstitutional in 88)
86: joint and several liability (except environmental, some products)
86: structured settlements

West Virginia

Wisconsin
95: joint and several liability

Wyoming
86: joint and several liability

Medical Malpractice "Tort Reforms"

Alabama
Pre-1985: collateral source
87: med mal cap (but declared unconstitutional in 91)
87: punitive cap (but declared unconstitutional in 93)
87: collateral source (but declared unconstitutional in part in 96)

Alaska
86: cap, non-economic
86: joint and several liability
86: collateral source rule
88: joint and several liability (ballot initiative)
97: cap, all damages
97: punitive cap
97: prejudgment interest

Arizona
Pre-1985: med mal collateral source
87: joint and several
89: med mal structured settlements (but declared unconstitutional in 94)

Arkansas
Pre-1985: medical malpractice structured settlements

California
Pre-1985: med mal cap, noneconomic; med mal collateral source; med mal contingency fees; med mal structured settlements
86: joint and several liability (ballot initiative)

Colorado
86: cap, noneconomic
86: joint and several liability
86: punitive cap
86: collateral source
88: med mal cap, all damages
88: med mal statute of repose
88: med mal structured settlements
92: med mal collateral source

Connecticut
85: med mal collateral source
86: joint and several (i.e. proportional) liability
86: contingency fees

Delaware
Pre-1985: collateral source; med mal contingency fees; med mal structured settlements

District of Columbia
Pre-1985: collateral source

Florida
86: joint and several liability
86: collateral source
86: med mal structured settlements
86: contingency fees
86 : punitive cap
88: cap noneconomic (but declared unconstitutional in 91)
88: med mal cap, noneconomic (depending on arbitration)

Georgia
87: punitive cap
87: joint and several liability

Hawaii
86: cap, noneconomic
86: joint and several liability (except medical products)
86: collateral source (liens)

Idaho
87: cap, noneconomic
87: joint and several liability
87: structured settlements
90: collateral source

Illinois
Pre-1985: med mal collateral source
85: medical malpractice structured settlements
85: med mal contingency fees
95: cap, noneconomic (but declared unconstitutional in 97)
95: joint and several liability (but declared unconstitutional in 97)
95: punitive cap (but declared unconstitutional in 97)

Indiana
Pre-1985: joint and several liability
86: collateral source
93: med mal cap, all damages
93: med mal contingency fee
95: punitive cap

Iowa
Pre-1985: joint and several liability; med mal collateral source
86: structured settlements
87: collateral source
87: prejudgment interest
87: structured settlements
97: joint and several liability
97: prejudgment interest

Kansas
85: med mal punitive cap (but expired in 88)
86: med mal cap (but declared unconstitutional in 88)
86: med mal structured settlements (but declared unconstitutional in 88)
87: cap, noneconomic
87: punitive cap
88: collateral source (but declared unconstitutional in 93)

Kentucky
88: joint and several liability (but codified common law rule)
88: collateral source (but declared unconstitutional in 95)

Louisiana
Pre-1985: med mal cap; med mal structured settlements (Patients Comp. fund); joint and several liability
87: joint and several liability
87: prejudgment interest
96: joint and several liability

Maine
85: med mal structured settlements
85: med mal contingency fees
88: prejudgment interest
89: med mal collateral source

Maryland
Pre-1985: collateral source
86: cap, noneconomic
86: structured settlements

Massachusetts
86: med mal cap, noneconomic
86: med mal collateral source
86: med mal contingency fees

Michigan
86: med mal cap, noneconomic
86: collateral source
86: structured settlements
86: prejudgment interest
87: joint and several liability
93: med mal cap, noneconomic
95: joint and several liability

Minnesota
86: cap, noneconomic (but repealed in 90)
86: collateral source
86: prejudgment interest
88: joint and several liability

Mississippi
89: joint and several liability
98: med mal statute of repose

Missouri
86: med mal cap, noneconomic
86: med mal structured settlements
87: joint and several liability
87: collateral source

Montana:
87: joint and several liability (but declared unconstitutional in 94)
87: collateral source
95: med mal cap, noneconomic
95: med mal structured settlements
97: joint and several liability

Nebraska
Pre-1985: collateral source; med mal cap (cap increased in 92)
86: prejudment interest (but improved prior standard)
92: joint and several liability (but improved prior standard)

Nevada
Pre-1985: med mal collateral source
87: joint and several liability
89: punitive cap

New Hampshire
86: cap, noneconomic (but declared unconstitutional in 91)
86: punitive abolished
89: joint and several liability
95: prejudgment interest

New Jersey
Pre-1985: contingency fees

87: joint and several liability
87: collateral source
95: punitive cap
95: joint and several liability

New Mexico
87: joint and several liability (but codified common law)
92: med mal structured settlement
92: med mal cap (except punitives)

New York
86: joint and several liability
86: collateral source
86: structured settlements
86: med mal contingency fees

North Carolina
95: punitive cap

North Dakota
87: joint and several liability
87: collateral source
87: structured settlements
93: punitive cap
95: med mal cap, noneconomic

Ohio
87: joint and several liability
87: structured settlements
96: cap, noneconomic
96: joint and several liability
96: punitive cap
96: collateral source
96: prejudgment interest

Oklahoma:
86: prejudgment interest
95: punitive cap

Oregon
87: cap, noneconomic
87: joint and several liability
87: med mal punitives abolished against doctors
87: collateral source
95: joint and several liability

Pennsylvania
Pre-1985: med mal collateral source
96: med mal punitive cap

Rhode Island
86: med mal collateral source
87: prejudgment interest

South Carolina
Pre-1985: med mal structured settlements (Patient Comp. Fund with annual cap)

South Dakota
Pre-1985: med mal collateral source; med mal cap; noneconomic
86: med mal cap, economic (but declared unconstitutional 96)
86: med mal structured settlements
87: joint and several liability

Tennessee
Pre-1985: med mal collateral source

Texas
87: med mal cap (but declared unconstitutional in 88, although allowed for wrongful death, 90)
87: joint and several liability (except environmental)
87: punitive cap
87: prejudgment interest
95: joint and several liability
95: punitive cap

Utah
85: med mal collateral source
86: med mal cap, noneconomic
86: joint and several liability
86: med mal structured settlements

Vermont:
Pre-85: joint and several liability

Virginia
Pre-1985: med mal cap (although cap raised in 83 and 99)
87: med mal (children injured at birth, no right to sue, no noneconomic or punitives)
87: punitive cap

Washington
Pre-1985: punitive cap; med mal collateral source
86: cap, all damages (but declared unconstitutional in 88)
86: joint and several liability
86: structured settlements

West Virginia
86: med mal cap, noneconomic
86: med mal joint and several liability

Wisconsin
Pre-1985: med mal (Patient Comp. Fund)
86: med mal cap, noneconomic (but expired 90)
86: med mal contingency fees
95: med mal cap
95: joint and several liability
95: med mal structured settlements
95: med mal collateral source

Wyoming
86: joint and several liability

APPENDIX B

GLOSSARY OF "TORT REFORMS"

GLOSSARY OF COMMON "TORT REFORMS"

Collateral Source Rule – The collateral source rule prevents a wrongdoer from reducing its financial responsibility for the injuries it causes by the amount an injured party receives (or could later receive) from outside sources. Payments from outside sources means those unrelated to the wrongdoer, like health or disability insurance, for which the injured party has already paid premiums or taxes. The rule also prevents juries from learning about such collateral payments, so as not to unfairly influence with verdict. States that have modified this rule have either completely repealed it, mandating that payments received from health insurance, social security or other sources be used to reduce the wrongdoer's liability. Or, they allow juries to hear during trial about collateral payments.

Caps (on Damages) – A damages cap is an arbitrary ceiling on the amount an injured party can receive in compensation by a judge or jury, irrespective of what the evidence presented at a trial proves compensation should be. A cap is usually defined in a statute by a dollar figure ($100,000, $500,000, etc.) Caps usurp the authority of judges and juries, who listen to the evidence in a case, to decide compensation based on each specific fact situation. Several states have declared caps unconstitutional.

Contingency Fees -- Under a contingency fee arrangement, a lawyer agrees to take a case on behalf of an injured client without obtaining any money up front from the client. This is a risk, because if the case is lost, the lawyer is paid nothing. In return, the lawyer is entitled to a percentage of the amount of money collected -- usually one-third -- if the case is successful. This system provides injured consumers who could not otherwise afford legal representation with access to the courts. Typically, states limit contingency fees by capping them sometimes way below one-third, sometimes along a sliding scale so fee percentages decrease, sometimes drastically, as judgments increases. The principal impact of contingency fee limits is to make it less likely attorneys can afford to risk bringing many cases, particularly the more costly and complex ones, providing practical immunity for many wrongdoers

Joint and Several Liability – The doctrine of joint and several liability is a fairness rule, developed over centuries to protect injured consumers. It applies when more than one defendant is found *fully responsible* for causing an injury (not 1% or 10% responsible, as is commonly misstated). If one wrongdoer is insolvent or cannot pay their share, the other fully-responsible wrongdoers must pick up the tab, to make sure the innocent victim is fully compensated. For example, suppose three toxic polluters recklessly contaminate drinking water, causing leukemia in neighborhood children. The actions of any one of them alone would be sufficient to cause leukemia. But because three companies are involved, each one's relative share becomes only one-third. This fortuitous circumstance allows them to split the total compensation each one owes the victims. But if one of those three companies becomes insolvent and cannot pay any compensation, who should cover it? Joint and several liability says that the other companies must cover the insolvent company's share. When joint and several liability is limited or abolished, however, these other wrongdoers are not required to cover the insolvent company's share, even if it means the innocent victim receives far less compensation for injuries than the judge or jury determined they deserve.

Non-economic Damages – Non-economic damages compensate injured consumers for intangible but real injuries, like infertility, permanent disability, disfigurement, pain and suffering, loss of a limb or other physical impairment. Limits on non-economic damages can have a disproportionate effect on plaintiffs who do not have high wages – like women who work inside the home, children, seniors or the poor, who are thus more likely to receive a greater percentage of their compensation in the form of non-economic damages if they are injured.

Prejudgment Interest – Prejudgment interest is the amount of interest that accrues on the value of an injured consumer's claim between the time he or she files a case, and the final judgment. Some states penalize victims by prohibiting pre-judgment interest or by imposing very low limits on pre-judgment interest rates. Laws that limit prejudgment interest can delay timely settlements or judgments in civil cases by reducing the monetary incentive that defendants have to resolve cases expeditiously.

Product Liability Defenses – The doctrine of "strict liability" has long applied in suits involving defective products. Strict liability ensures that one who is responsible for bringing a dangerously defective product into the marketplace or workplace compensates those injured by the product. However, some states have enacted new defenses for those who manufacturer or sell defective products. For example, some laws establish a presumption that an injury-causing product, drug or medical device is not defective or unreasonably dangerous if the product complies with government standards. This benefits manufacturers that profit from weak and long out-of-date health and safety standards, like manufacturers of cars, trains, factory equipment, and school buses. Other provisions require an injured consumer to prove the existence of an "alternative design" for a defective product, which would have prevented the harm but would not have hurt the product's marketability. This forces plaintiffs, who are at a distinct disadvantage when it comes to knowledge about technical design alternatives, to prove the existence of such alternatives when this defense is raised. Other laws immunize manufacturers that produce products with design defects if the products have "obvious risks," like tobacco, or are considered "unavoidably unsafe," like guns -- even if a defective gun accidentally discharges and kills someone.

Punitive Damages – Punitive damages, also known as "exemplary damages," are assessed against defendants by judges or juries to punish particularly outrageous, deliberate or harmful misconduct, and to deter the defendant and others from engaging in similar misconduct in the future. It is well recognized that the prospect of having to pay punitive damages in a lawsuit by an injured consumer causes corporations to build safer products and operate more safely. Many dangerous and defective products -- including the Ford Pinto, asbestos, and the Dalkon Shield IUD -- were removed from the market because of punitive damages.

Statute of Repose – A statute of repose for products completely cuts off liability of the manufacturer or seller of a defective product after an arbitrarily-established number of years, such as 10 years or 15 years. (A few states have adopted statutes of repose to cut off doctors' and hospitals' liability for medical malpractice, as well.) Statutes of repose apply no matter how serious the injuries, how many injuries have been caused over the years by these products or services, or how reckless the actions of the wrongdoer were. They cover products with expected lives much longer than typical cut-off dates in the statute of repose, products like nuclear power plant components, medical devices such as pacemakers, elevators, airplanes, home appliances, playground equipment, farm equipment, freight trains, trucks, and other industrial machinery.

Structured Settlements – Also called "periodic payments," structured settlement laws either mandate, allow defendants to request, or allow courts to require that some or all payments awarded by a judge or jury be made to the injured consumer over a long period of time. In other words, the injured consumer is prohibited from receiving payments in a lump sum. These provisions increase the hardships of the most seriously injured consumers who are hit soon after an injury with large medical costs and must make adjustments in transportation and housing. Often, the law allows insurance companies to pocket the money upon the plaintiff's death, instead of paying it to a dependent spouse or child.

APPENDIX C

ISO DATA ANALYSIS

EXHIBIT I – GENERAL TORT

	State	Special Multi-Peril Liability 85 to 98 change	Comm. Auto Basic Liability 85 to 98 change	Personal Liability 85 to 98 change	OL&T Liability 85 to 98 change	M&C Liability 85 to 98 change	Severity Of Tort Law Change	Overall Change	Comm. Multi-Peril 1997 Earned Premiums (in millions of $)	Comm. Auto Liab 1997 Earned Premiums (in millions of $)	EST Personal Liability** 1997 Earned Premiums (in millions of $)	Other Liability** 1997 Earned Premiums (in millions of $)
1	Missouri	0.894	1.354	0.707	1.365	0.78	2	1.051	386	238	60	447
2	Ohio	0.916	1.354	0.512	1.171	1.301	3	1.115	707	479	123	829
3	Iowa	1.136	1.175	0.546	1.427	0.866	3	1.125	169	141	25	247
4	Michigan	1.164	0.991	0.685	1.429	1.037	3	1.134	698	359	106	778
5	Wisconsin	1.103	1.156	1.114	1.402	1.226	1	1.192	344	241	50	357
6	Minnesota	0.892	1.814	0.517	1.472	0.92	3	1.195	325	231	66	471
7	Indiana	0.88	1.67	0.604	1.523	1.095	2	1.196	432	284	66	359
8	Kansas	1.083	1.06	0.876	1.783	1.169	3	1.203	178	111	26	168
9	Virginia	1.197	1.244	0.796	1.600	0.927	1	1.204	372	286	82	417
10	Massachusetts*	0.963	0.961	1.785	1.913	1.328	1	1.259	612	449	103	720
11	Pennsylvania	1.164	1.317	1.085	1.278	1.519	1	1.283	976	634	166	1092
12	Maryland	0.977	1.633	0.958	1.847	0.938	2	1.289	329	254	73	386
13	Maine	1.183	1.385	0.684	1.773	1.31	1	1.306	109	63	12	67
14	Florida	1.313	1.322	0.916	1.616	1.12	3	1.306	1260	823	248	1186
15	Arizona	1.041	1.869	0.885	1.573	1.009	2	1.309	291	200	66	315
16	North Dakota	1.019	1.263	0.514	2.120	1.46	3	1.322	41	33	6	41
17	Washington	1.217	1.577	0.945	1.608	1.157	2	1.327	435	228	79	388
18	Arkansas	0.936	1.481	0.482	2.041	1.579	1	1.347	155	138	28	150
19	Alaska	1.245	1.027	1.22	2.011	1.47	3	1.378	68	33	7	60
20	Oregon	1.067	1.516	0.901	2.601	1.037	3	1.384	275	148	44	204
21	Nebraska	1.213	1.152	0.57	2.500	1.133	1	1.400	122	83	17	138
22	Georgia	1.051	1.686	0.706	1.994	1.282	2	1.421	448	397	84	557
23	Montana	1.133	1.408	0.777	2.491	1.511	2	1.447	68	52	9	53
24	Colorado	1.013	1.454	0.89	2.936	0.99	3	1.460	323	171	61	358
25	Idaho	1.327	1.393	0.785	2.507	1.157	3	1.475	91	57	12	74
26	Tennessee	1.093	1.999	0.704	1.890	1.161	1	1.475	312	274	53	335

	State	Special Multi-Peril Liability 85 to 98 change	Comm. Auto Basic Liability 85 to 98 change	Personal Liability 85 to 98 change	OL&T Liability 85 to 98 change	M&C Liability 85 to 98 change	Severity Of Tort Law Change	Overall Change	Comm. Multi-Peril 1997 Earned Premiums (in millions of $)	Comm Auto Liab 1997 Earned Premiums (in millions of $)	EST Personal Liability** 1997 Earned Premiums (in millions of $)	Other Liability** 1997 Earned Premiums (in millions of $)
27	New Hampshire	0.951	1.912	1.284	1.705	1.889	3	1.479	123	65	14	124
28	Dist. Of Columbia	1.352	1.467	1.435	1.655	1.471	1	1.489	74	30	5	148
29	Oklahoma	1.285	1.107	0.77	2.856	1.438	2	1.496	214	155	37	203
30	Utah	1.188	1.629	0.884	2.162	1.646	2	1.500	131	81	23	110
31	Illinois	1.054	1.337	1.242	2.184	1.489	2	1.519	922	543	125	1766
32	Kentucky	1.394	1.582	0.813	2.832	1.276	1	1.606	239	185	49	209
33	Connecticut	0.965	1.699	0.719	2.177	1.954	3	1.615	366	233	62	607
34	Vermont	0.988	2.111	0.795	2.606	1.566	1	1.631	60	30	6	64
35	South Carolina	1.071	1.652	0.938	2.887	2.038	1	1.646	220	182	42	190
36	Hawaii*	1.332	1.501	1.162	2.492	1.645	3	1.647	117	70	21	136
37	New Mexico	1.403	1.476	1.087	2.794	1.686	1	1.647	114	70	22	88
38	South Dakota	1.294	1.443	0.543	3.637	1.28	2	1.721	48	37	7	53
39	Wyoming	1.009	1.186	0.886	4.233	2.136	2	1.734	42	24	5	33
40	Nevada	1.463	2.442	1.122	2.445	1.321	2	1.785	147	84	31	131
41	New York	1.06	2.055	1.278	2.510	2.16	3	1.792	2034	1112	270	2459
42	New Jersey	1.492	2.128	1.153	2.572	1.455	3	1.827	880	704	166	1040
43	North Carolina	1.39	2.186	1.252	3.359	1.242	1	1.906	412	375	92	424
44	West Virginia	1.21	1.415	1.135	4.394	2.128	1	1.907	99	92	24	98
45	Rhode Island	1.146	2.521	1.086	3.335	1.538	2	1.911	90	57	18	93
46	Mississippi	1.297	2.136	1.261	3.425	1.557	1	1.924	153	147	23	141
47	Alabama	1.409	1.91	0.611	3.841	1.405	2	1.934	284	222	39	299
48	Louisiana	1.569	2.02	0.877	4.563	1.782	2	2.241	277	283	67	365
49	Delaware	1.547	2.628	1.313	4.592	1.131	1	2.437	58	58	13	130
50	California*	1.452	1.332	1	1.347	1.92	Incomptl data	na	na	1306	na	3024
51	Texas*	1.072	0.951	1.381	3.066	2.807	Incomptl data	na	na	956	na	1510

* Hawaii, Massachusetts and Texas are Commercial Auto Rate Bureau States. Hawaii is a Personal Liability Rate Bureau State. Data may be understated. Also, a review of the data makes it clear that California and Texas data are incomplete from ISO.
**Personal Liability Premium estimated at 5% of Personal auto liabilit. Weight Given to M&C and OL&T is 50% of Other Liability.

Appendix C – Exhibit 1 – General Tort 2

Exhibit 2 – Products Liability

	STATE	Products Liability 85 to 98 Change	Severity of Tort Law Change	Products Liability 1997 Earned Premiums (in millions of $)
1	Kentucky	0.834	1	972
2	Illinois	0.892	2	2503
3	Oklahoma	1	2	747
4	Wyoming	1.07	2	92
5	Hawaii *	1.212	2	413
6	Texas	1.362	3	5561
7	Oregon	1.41	3	870
8	Alabama	1.421	2	776
9	Massachusetts	1.429	1	2061
10	California	1.45	2	8541
11	Louisiana	1.507	3	1345
12	Connecticut	1.535	3	1232
13	Maine	1.557	2	243
14	Iowa	1.581	3	509
15	New Hampshire	1.581	3	282
16	Indiana	1.606	2	1323
17	Tennessee	1.624	1	1061
18	Georgia	1.624	2	1683
19	Missouri	1.627	2	1190
20	Nebraska	1.633	1	336
21	Mississippi	1.664	2	454
22	New York	1.673	3	5396
23	Utah	1.713	2	464
24	South Dakota	1.721	2	146
25	West Virginia	1.752	1	486
26	Arizona	1.754	2	1312
27	Dist. of Col.	1.766	1	107
28	Montana	1.77	2	172
29	Michigan	1.793	3	2121
30	Minnesota	1.815	3	1323
31	Kansas	1.816	3	523
32	South Carolina	1.818	1	839
33	Arkansas	1.826	1	568
34	Colorado	1.829	3	1220
35	Wisconsin	1.842	1	999
36	Nevada	1.856	1	618
37	Ohio	1.88	3	2460
38	North Carolina	1.902	1	1834

39	Maryland	1.909	2	1450
40	Rhode Island	1.944	1	350
41	North Dakota	1.958	3	113
42	Delaware	1.979	1	264
43	Florida	2.059	3	4950
44	New Mexico	2.061	1	437
45	Virginia	2.095	1	1645
46	Pennsylvania	2.098	1	3313
47	New Jersey	2.116	3	3311
48	Idaho	2.126	3	242
49	Alaska	2.14	3	146
50	Washington	2.325	2	1586
51	Vermont	2.369	1	117

* Hawaii is a Product Liability Rate Bureau state. Data may thus be understated

EXHIBIT 3 – MEDICAL MALPRACTICE

	STATE	Hospital Professional Liability 85 to 98 change	Physicians, Surgeons & . Denstists Liability 85 to 98 change	Average of Hospital and PS&D = Med Mal. 85 to 98 change	Severity of Tort Law Change	1997 Medical Malpractice Earned Premiums (millions of $)
1	Utah	1.571	0.652	1.112	3	30
2	Washington	1.322	0.984	1.153	2	99
3	Rhode Island	1.14	1.236	1.188	2	22
4	Minnesota	1.644	0.892	1.268	3	52
5	Nevada	0.922	1.842	1.382	2	45
6	South Dakota	1.977	0.995	1.486	2	11
7	Florida	1.847	1.16	1.504	3	403
8	Maine	1.694	1.321	1.508	3	25
9	New Mexico	0.914	2.159	1.537	1	29
10	Illinois	0.668	2.436	1.552	2	380
11	Dist. of Col.	1.536	1.597	1.567	1	34
12	Wisconsin	1.987	1.188	1.588	2	65
13	West Virginia	0.879	2.412	1.646	2	44
14	Massachusetts	1	2.5	1.750	3	178
15	Iowa	2.002	1.535	1.769	3	44
16	Connecticut	2.312	1.23	1.771	3	127
17	Alaska	0.922	2.727	1.825	3	13
18	Hawaii	1	2.732	1.866	3	22
19	North Dakota	2.518	1.415	1.967	3	13
20	South Carolina	1.481	2.605	2.043	1	11
21	California	1.731	2.435	2.083	1	629
22	Oregon	3.198	1.009	2.104	3	39
23	Kentucky	2.951	1.528	2.240	1	59
24	Indiana	1.977	2.631	2.304	2	38
25	Colorado	3.326	1.597	2.462	3	90
26	New Jersey	3.356	1.671	2.514	2	290
27	Michigan	2.116	2.982	2.549	3	189
28	Missouri	2.452	2.683	2.568	3	114
29	Nebraska	3.19	2.116	2.653	1	20
30	New York	3.017	2.389	2.703	3	809
31	Georgia	3.578	2.118	2.848	2	179
32	Montana	4.678	1.053	2.866	2	15
33	Tennessee	3.975	1.959	2.967	1	154
34	North Carolina	3.537	2.454	2.996	1	117
35	Mississippi	3.843	2.328	3.086	1	31
36	Arizona	3.795	2.385	3.090	1	120

37	Idaho	5.055	1.353	3.204	3	18
38	Oklahoma	3.147	3.48	3.314	1	71
39	Pennsylvania	5.045	2.25	3.648	1	217
40	Maryland	5.882	1.426	3.654	2	115
41	Delaware	5.55	1.774	3.662	1	18
42	Kansas	3.354	4.075	3.715	2	40
43	Ohio	4.893	2.762	3.828	2	198
44	Arkansas	4.586	3.178	3.882	1	32
45	Vermont	6.378	1.995	4.187	1	8
46	Alabama	7.451	1.731	4.591	1	94
47	Wyoming	6.617	3.362	4.990	1	11
48	Virginia	6.942	3.073	5.008	2	112
49	New Hampshire	10.139	1.967	6.053	2	20
50	Louisiana	4.233	29.311	16.772	2	66
51	Texas*	1	1	NA	Data in-complete	340

* A review of the data makes it clear that Texas data are incomplete from ISO.

VITALSMARTS™ INDUSTRY WATCH

SILENCE KILLS

The Seven Crucial Conversations® for Healthcare

AMERICAN ASSOCIATION of CRITICAL-CARE NURSES

VitalSmarts™

crucial conversations®

Silence Kills

The Seven Crucial Conversations for Healthcare

David Maxfield, Joseph Grenny, Ron McMillan, Kerry Patterson, Al Switzler

NASA employs some of the smartest and most dedicated professionals in the world. Individually they are the cream of the crop in their various science, engineering, and administrative disciplines. Their collective achievements have dramatically expanded the boundaries of our knowledge of both our universe and our world. And yet in spite of their individual dedication and collective brilliance, on February 1, 2003, seven astronauts died—perhaps unnecessarily—when the *Columbia* Shuttle Mission STS-107 incinerated on reentry into the earth's atmosphere. The reason? A key contributor to the tragedy was a culture that "prevented effective communication of critical safety information and stifled professional differences of opinion."[1] People's inability to confront risky topics allowed risks to go unaddressed—contributing to the loss of seven lives.

Those who serve daily in U.S. hospitals could be described as similarly intelligent and dedicated. In the aptly titled report *To Err is Human*[2], the Institute of Medicine acknowledges both the individual dedication and collective contributions of those who give their all to improve and save the lives of patients in our healthcare institutions. And yet, as the report points out, each year hundreds of thousands of patients are brought to harm in the course of their healing because of fundamental problems in the collective behavior of these caring professionals. These problems are not unlike those that contributed to the loss of *Columbia*. For example, each year one in twenty in-patients at hospitals will be given a wrong medication, 3.5 million will get an infection from someone who didn't wash his or her hands or take other appropriate precautions[3], and 195,000 will die because of mistakes made while they're in the hospital.[4]

© 2005 VitalSmarts, L.C. All Rights Reserved. VitalSmarts is a trademark and Crucial Conversations is a registered trademark of VitalSmarts, L.C.

Hospitals are responding aggressively to this crisis with new technologies, quality-improvement systems, and methods of organizing. However, though the healthcare community is taking needed action on a number of fronts, there is a deeper problem that must be resolved before acceptable levels of improvement will be attainable.

As with NASA personnel, key problems that contribute to these tragic errors are often known far in advance. And yet few people talk about them. Every day, many healthcare workers stand next to colleagues and see them cut corners, make mistakes, or demonstrate serious incompetence. But only a small percentage speak up and discuss what they have seen—even though they're standing only a few feet away. As a result, problems go on for years—contributing to avoidable errors, high turnover, decreased morale, and reduced productivity. Just as the unwitting behavior of well-intended NASA personnel served to suppress key information that might have escalated risks, many healthcare workers tend to act in ways that allow risks and problems to remain unaddressed—sometimes for years.

> *A group of eight anesthesiologists agree a peer is dangerously incompetent, but they don't confront him. Instead, they go to great efforts to schedule surgeries for the sickest babies at times when he is not on duty. This problem has persisted for over five years.* (Focus Group of Physicians)

> *A group of nurses describe a peer as careless and inattentive. Instead of confronting her, they double check her work—sometimes running in to patient rooms to retake a blood pressure or redo a safety check. They've "worked around" this nurse's weaknesses for over a year. The nurses resent her, but never talk to her about their concerns. Nor do any of the doctors who also avoid and compensate for her.* (Focus Group of Nurses)

Past studies have indicated that more than 60 percent of medication errors are caused by mistakes in interpersonal communication. The Joint Commission on Accreditation of Healthcare Organizations suggests that communication is a top contributor to sentinel events.[5] This study builds on these findings by exploring the specific concerns people have a hard time communicating that may contribute to avoidable errors and other chronic problems in healthcare.

The study we report here suggests that there are seven *crucial conversations* that people in healthcare frequently fail to hold that likely add to unacceptable error rates. The nationwide study was conducted by VitalSmarts in partnership with the American Association of Critical-Care Nurses. This study suggests that improvement in these seven crucial conversations could not only contribute to significant reductions in errors, but also to improvements in quality of care, reduction in nursing turnover, and marked improvement in productivity.

In addition, we will offer healthcare leaders a simple method for measuring their current performance in these seven crucial conversations, as well as an action plan for making measurable improvement in this key competency.

© 2005 VitalSmarts, L.C. All Rights Reserved. VitalSmarts is a trademark and Crucial Conversations is a registered trademark of VitalSmarts, L.C.

The Study

Researchers conducted dozens of focus groups, interviews, and workplace observations, and then collected survey data from more than 1,700 respondents, including 1,143 nurses, 106 physicians, 266 clinical-care staff, and 175 administrators during 2004. Their research sites included thirteen urban, suburban, and rural hospitals from across the U.S. These included a mix of teaching, general, and pediatric hospitals. Although this is a modest sample, the findings fit together in a significant and compelling way.

The study identified the categories of conversations that are especially difficult and, at the same time, especially essential for people in healthcare to master. The study showed that the quality of these crucial conversations relates strongly with medical errors, patient safety, quality of care, staff commitment, employee satisfaction, discretionary effort, and turnover. We grouped these concerns into seven areas: Broken Rules, Mistakes, Lack of Support, Incompetence, Poor Teamwork, Disrespect, and Micromanagement.

More than half of the healthcare workers surveyed in this study had occasionally witnessed broken rules, mistakes, lack of support, incompetence, poor teamwork, disrespect, and micromanagement. Many had seen some of their colleagues cutting corners, making mistakes, and demonstrating serious incompetence. However, even though they had these concerns, fewer than one in ten fully discussed their concerns with the coworker. Furthermore, most healthcare workers neither believe it's possible nor even their responsibility to call attention to these issues.

About half of respondents say the concerns have persisted for a year or more. And a significant number of those who have witnessed these persistent problems report injurious consequences. For example, one in five physicians say they have seen harm come to patients as a result of these concerns, and 23 percent of nurses say they are considering leaving their units because of these concerns.

On the positive side, this study shows that healthcare workers who are confident in their ability to raise these crucial concerns observe better patient outcomes, work harder, are more satisfied, and are more committed to staying. About 10 percent of the healthcare workers surveyed fall into this category. While additional confirming research is needed, the implication is that if more healthcare workers could learn to do what this influential 10 percent seem to be able to do systematically, the result would be significantly fewer errors, higher productivity, and lower turnover.

© 2005 VitalSmarts, L.C. All Rights Reserved. VitalSmarts is a trademark and Crucial Conversations is a registered trademark of VitalSmarts, L.C.

Prevalence of the Seven Most Crucial Concerns

Participants were asked to indicate the percentage of their coworkers with whom they had each of the seven crucial concerns. They had to indicate that at least 10 percent of their coworkers were in violation to be categorized as "seeing the concern." It is important to point out that respondents consistently report that the vast majority of healthcare workers *do not* exhibit the problems described below. And yet the vast majority of healthcare workers *do* see some number who not only exhibit the problems, but also continue to do so for long periods of time without being held accountable.

1. **Broken Rules:** 84 percent of physicians and 62 percent of nurses and other clinical-care providers see some number of their coworkers taking shortcuts that could be dangerous to patients. This concern was focused on a relatively small number of their colleagues. The median was 10 percent, meaning that they were comfortable with 90 percent of their colleagues' ability.

   "A phlebotomist in a neonatal unit would slip on her gloves and immediately tear the tip of the index finger off her glove, so she could feel the baby's vein better and wouldn't miss. I talked to her about it twice. Finally I said, 'If I ever see you tear the finger out of another glove I will write you up for a willful violation.' Now she follows the rules." (Nurse Manager)

2. **Mistakes:** 92 percent of physicians and 65 percent of nurses and other clinical-care providers work with some people who have trouble following directions; 88 percent of physicians and 48 percent of nurses and other clinical-care providers see some colleagues show poor clinical judgment when making assessments, doing triage, diagnosing, suggesting treatment, or getting help. Again, these respondents are pointing to a relatively small minority of their colleagues—the median was again just 10 percent.

   "Some docs can make incorrect orders. We let it slide—especially if it is a jerk . . . For example, one physician prescribed a drug that you should give three times a day, but he said to give it twice a day. I let it go, because it was just a pain pill. It wasn't going to make the child any sicker." (Pharmacist.)

3. **Lack of Support:** 53 percent of nurses and other clinical-care providers report that 10 percent or more of their colleagues are reluctant to help, impatient, or refuse to answer their questions. 83 percent have a teammate who complains when asked to pitch in and help. On the positive side, 76 percent say that half or more of their colleagues give them emotional support when they are down, and 64 percent say that half or more of their colleagues pick up a share of their work when they need help. It's clear that most people provide support. The problem is with a small minority who don't.

   "Some people here are burnt out. They've lost the excitement or have some personal issue in their life . . . People have to cover for them, pick up their slack. People get mad at them, isolate them, don't offer to help them, shy away from them. If they need extra help, they don't get it. They don't call or ask for it." (Nurse)

© 2005 VitalSmarts, L.C. All Rights Reserved. VitalSmarts is a trademark and Crucial Conversations is a registered trademark of VitalSmarts, L.C.

4. **Incompetence:** 81 percent of physicians and 53 percent of nurses and other clinical-care providers have concerns about the competency of some nurse or other clinical-care provider they work with; 68 percent of physicians and 34 percent of nurses and other clinical-care providers have concerns about the competency of at least one physician they work with.

   "There is a cardiologist who everybody feels is incompetent. He makes himself very accessible to general practitioners, so he gets a lot of referrals, but those of us who have to work with him—the thoracic surgeons, the anesthesiologists, the other cardiologists—would never put someone under his care." (Physician)

5. **Poor Teamwork:** 88 percent of nurses and other clinical-care providers have one or more teammate who gossips or is part of a clique that divides the team. 55 percent have a teammate who tries to look good at others' expense.

   "We have a nurse who is like your eccentric aunt—she's a bully. She makes unreasonable demands like, 'I won't take any more patients today.' She gets away with it. She's a very good nurse, but she's ornery and a bully. She doesn't do her fair share. It ticks all of us off. We've lost a couple of good nurses here because they were sick of putting up with her and our supervisor won't deal with her." (Nurse)

6. **Disrespect:** 77 percent of nurses and other clinical-care providers work with some who are condescending, insulting, or rude. 33 percent work with a few who are verbally abusive—yell, shout, swear, or name call.

   "A group of physicians went right into the patient's room without gowns or masks or gloves. This was a patient who was supposed to be in isolation. We didn't confront them because that cardio surgeon has a reputation. He belittles nurses by saying things like, 'Do they have any nurses on this unit who aren't stupid?' If you question him, he starts yelling, and turns it into a war." (Nurse)

7. **Micromanagement**: 52 percent of nurses and other clinical-care providers work with some number of people who abuse their authority—pull rank, bully, threaten, or force their point of view on them.

   "We have a charge nurse who . . . pages us to come to the desk so she can tell us what to do . . . She will come into the room where we have a sick patient and she'll take over . . . She'll say, 'Do it because I say so.' Sometimes when she bosses me around I feel less inclined to correct her when she's wrong about how to treat the child. I'm sure I've gone along with something I shouldn't have because I resent her. But basically, I've started looking at other hospitals for a job." (Nurse)

© 2005 VitalSmarts, L.C. All Rights Reserved. VitalSmarts is a trademark and Crucial Conversations is a registered trademark of VitalSmarts, L.C

The Impact of these Crucial Conversations

Most healthcare respondents are happy in their careers and believe their organizations do good work. And yet most respondents report that a number of their colleagues create problems that are common, frequent, persistent, and dangerous. And, most important, the data show these problems are rarely addressed.

The study focused in detail on three of the seven crucial conversations: incompetence, poor teamwork, and disrespect. In these three areas the study mapped the frequency, duration, and impacts of people's concerns. It also measured whether and how these concerns were addressed.

Incompetence

The survey asked about a variety of competency issues, ranging from "poor clinical judgment" to "making decisions beyond their competency level" to "missing basic skills." Respondents indicated whether they had coworkers who are incompetent in these areas. Next, respondents were asked to think of the coworker with the worst competency problem, and to rate how often this person does something dangerous, how long the problem has gone on, and how the person's competency has impacted patient health and safety.

The data in tables 1-a and 1-b reveal the scope of the problem. Most healthcare workers have serious concerns about the competence of some of their coworkers. In fairness, a person's perceptions of another's competence can sometimes be just a difference of judgment—and nowhere more than in a field as complex and often ambiguous as healthcare. And yet the prevalence of the perceptions, along with strong anecdotal data from focus group interviews, suggest that real problems exist. Many cite a coworker who does something dangerous as often as every month. Nearly half report the problem has continued for a year or more. Some have witnessed the person causing harm to patients. And yet only a small percentage discuss their concerns with the person.

The data show it is much tougher to confront a physician than to confront a nurse or other clinical-care provider. Interestingly, the data also show physicians are about as unlikely to confront nurses and other clinical-care providers as they are to confront physicians, even though their clinical authority would seem to make it an easier discussion.

© 2005 VitalSmarts, L.C. All Rights Reserved. VitalSmarts is a trademark and Crucial Conversations is a registered trademark of VitalSmarts, L.C.

Nurses and Other Clinical Care Providers' Concerns about Incompetence

53% are concerned about a peer's competence.	This peer does something dangerous at least once a month.	27%
12% have spoken with this peer and shared their full concerns.	The problem with this peer has gone on for a year or more.	48%
	A patient has been harmed by this person's actions during the last year.	7%
34% are concerned about a physician's competence.	This physician does something dangerous at least once a month.	19%
Less than 1% have spoken with this physician and shared their full concerns.	The problem with this physician has gone on for a year or more.	54%
	A patient has been harmed by this physician's actions during the last year.	8%

Table 1-a

Physicians' Concerns about Incompetence

81% are concerned about a nurse's or other clinical-care provider's competence.	This person does something dangerous at least once a month.	15%
	The problem with this person has gone on for a year or more.	46%
8% have spoken with this person and shared their full concerns.	A patient has been harmed by this person's actions during the last year.	9%
68% are concerned about a physician's competence.	This physician does something dangerous at least once a month.	21%
Less than 1% have spoken with this physician and shared their full concerns.	The problem with this physician has gone on for a year or more.	66%
	A patient has been harmed by this physician's actions during the last year.	19%

Table 1-b

© 2005 VitalSmarts, L.C. All Rights Reserved. VitalSmarts is a trademark and Crucial Conversations is a registered trademark of VitalSmarts, L.C.

Poor Teamwork

The survey examined a variety of teamwork concerns, ranging from "gossiping" to "making themselves look good at your expense" to "not doing their fair share of the work." Respondents indicated whether they had coworkers who demonstrated poor teamwork in these areas. Next, respondents were asked to think of the coworker whose poor teamwork has the most negative impact, and to rate how often this person does something that undermines the team, how long the problem has gone on, and how the person's poor teamwork has impacted patient care and employee morale.

The data in Table 2 show a widespread problem. Three-quarters of the healthcare workers surveyed are concerned about a teamwork issue, and more than two-thirds say this problem has gone on for over a year. A smaller—yet significant—number (one-fifth) say the teamwork issue is so severe they can't trust that patients are getting the right level of care, and even more are seriously considering leaving their jobs because of the teamwork issue. And yet relatively few ever discuss their concerns with the person involved.

Nurses and Other Clinical Care Providers' Concerns about Poor Teamwork

75% are concerned about a peer's poor teamwork.	This peer does something that undercuts the team at least once a month.	61%
	The problem with this peer has gone on for a year or more.	69%
16% have spoken with this peer and shared their full concerns.	Because of this teamwork issue, the respondent can't trust that patients in their area are receiving the right level of care.	22%
	Because of this teamwork issue, the respondent is seriously considering leaving the unit or the hospital.	23%

Table 2

© 2005 VitalSmarts, L.C. All Rights Reserved. VitalSmarts is a trademark and Crucial Conversations is a registered trademark of VitalSmarts, L.C

Disrespect

The survey asked about disrespectful and abusive behavior, ranging from "verbal abuse" to "condescending, insulting, or rude" to "bullying and threatening." Respondents indicated whether they worked with people who were abusive toward them in these ways. Next, respondents were asked to think of the person whose abuse has the most negative impact, and to rate how often this person is disrespectful or abusive toward them, and how long the problem has gone on.

The data in Table 3 show that three-quarters of the healthcare workers surveyed experience some level of disrespect. For many, the treatment is frequent and long-standing. The correlations show that the more frequent the behavior and the longer it has gone on, the greater the workers' intent to quit their jobs. In fact, these correlations are so strong (correlations where r>.1 are meaningful—here we find r=.424, which is impressive) that disrespectful behavior is suggested to be a primary cause of people's desire to quit. Discussing their concerns with the person who is responsible for the abuse is almost out of the question.

Nurses and Other Clinical Care Providers' Concerns about Disrespect and Abuse

77% are concerned about disrespect they experience.	This person is disrespectful or abusive toward them in at least a quarter of their interactions.	28%
	The behavior has gone on for a year or more.	44%
7% have spoken with this peer and shared their full concerns.	Correlation between the frequency of mistreatment and intent to quit their job.	r = .424, p < .001
	Correlation between the duration of abuse and intent to quit their job.	r = .190, p < .001

© 2005 VitalSmarts, L.C. All Rights Reserved. VitalSmarts is a trademark and Crucial Conversations is a registered trademark of VitalSmarts, L.C

Why Don't People Speak Up and Share Their Full Concerns?

The obvious reason is that confronting people is difficult. In fact, most respondents to the survey indicated it was between difficult and impossible to confront people in these crucial situations. People's lack of ability, belief that it is "not their job," and low confidence that it will do any good to have the conversation are the three primary obstacles to direct communication.

When the Concern Is...	Percentage Saying It Is Difficult to Impossible to Confront the Person
Incompetence	56% of Physicians 72% of Nurses and other Clinical-Care Providers
Poor Teamwork	78% of Nurses and other Clinical-Care Providers
Disrespect or Abuse	59% of Nurses and other Clinical-Care Providers

Table 4

Other obstacles include time and fear of retaliation. The survey asked respondents to indicate the reasons they didn't confront people when they had these important concerns. The reasons they selected were similar for each concern, with the most common reasons being: "There wasn't a time or opportunity," "It's not my role," "I've seen them get angry," and "I thought they would retaliate." People don't want to make others angry or undercut their working relationships, so they leave difficult discussions to others or to another time, and never get back to the person.

However, some people don't remain silent about the problems they see. They talk about them with others. Depending on the nature of the problem, a quarter to half of the respondents discussed the problem with coworkers or with the person's manager. In interviews, participants suggested that the purpose for discussing these problems with coworkers is not to solve problems. Instead, it's to work around them, warn others about them, and blow off steam. The comments below, taken from focus groups, illustrate these workarounds, warnings, and venting sessions.

> *"We all know who I'm talking about. She has bad habits, or is missing good ones. She gets busy and leaves the rails down on an infant bed or the door open on an incubator. We all check on her patients just to make sure about things."* (Nurse)

> *"People give you the word. A nurse will call from surgery and say, 'He's in a mood.' If something goes wrong in surgery, he'll come in yelling at people. You are just waiting for your turn."* (Nurse)

© 2005 VitalSmarts, L.C. All Rights Reserved. VitalSmarts is a trademark and Crucial Conversations is a registered trademark of VitalSmarts, L.C.

> *"She can't be trusted with cases. She can give meds, but she won't ever get it. She's been there for seven months. This nurse would do fine in a doctor's office, but won't make it in the hospital. The other nurses all agree."* (Nurse)

Most respondents also say going to the person's manager creates problems.

> *"I'm embarrassed. I saw a nurse cutting corners and instead of talking to her I talked to her boss. Here's the situation. I used to be this nurse's boss, but now she's training me and we are peers. I should have gone to her, but I was concerned about our relationship and I went to her boss instead. It was a bad move."* (Nurse Practitioner)

The data suggest that going to the person's manager is, indeed, a bad move. Although managers are somewhat more likely than employees to confront the person and fully discuss the problem, they are still very unlikely to do so. Taking a concern to a manager was often a dead end.

When the Concern Is	Percentage of Non-Supervisory Employees Who Confront the Person	Percentage of Supervisors Who Confront the Person
Competence of a Nurse or other Clinical-Care Provider	3%	16%
Competence of a Physician	Less than 1%	Less than 1%
Poor Teamwork	5%	9%
Disrespect or Abuse	2%	5%

Table 5

People Who Do Step Up to these Crucial Conversations

Within each hospital there is a fascinating minority, 5–15 percent of healthcare workers, depending on the issue, who step up to these crucial conversations. They work in the same units or departments as the 85–95 percent of their coworkers who don't feel able to speak up. Are they crazy? Are they destroyed by the unsafe environment? No; these people prove that it's possible to discuss serious concerns in almost any environment and succeed.

© 2005 VitalSmarts, L.C. All Rights Reserved. VitalSmarts is a trademark and Crucial Conversations is a registered trademark of VitalSmarts, L.C.

The significant correlations in Table 6 show that people who are confident in their ability to have crucial conversations achieve positive outcomes for their patients, for the hospital, and for themselves. This is counterintuitive. Most of those who don't speak up believe that to do so would lead to disaster. The opposite seems to be the case for this critical minority of interpersonally skilled individuals. Again, the correlations of from .2 up to .465 suggest that these peoples' ability to deal with tough interpersonal challenges is highly related to all of the outcomes described. The "p<.001" means that the odds that this strong relationship is due to chance is less than 1 in 1000.

Nurses and other clinical-care providers who are confident in their ability to confront people when the concern is Incompetence	Observe better patient outcomes (Spearman correlation = -.336, p < .001)
	Are more satisfied with their workplace (Spearman correlation = -.267, p < .001)
	Exhibit more discretionary effort[6]—work beyond the minimum required (Spearman correlation = -.240, p < .001)
	Intend to stay in their unit and hospital (Spearman correlation = -.335, p < .001)
Physicians who are confident in their ability to confront people when the concern is Incompetence	Observe better patient outcomes (Spearman correlation = -.307, p < .001)
	Are more satisfied with their workplace (Spearman correlation = -.309, p < .001)
	Exhibit more discretionary effort—work beyond the minimum required (Spearman correlation = -.263, p < .001)
Nurses and other clinical-care providers who are confident in their ability to confront people when the concern is Poor Teamwork	Observe better patient care (Spearman correlation = -.310, p < .001)
	Have higher morale (Spearman correlation = -.465, p < .001)
	Exhibit more discretionary effort—work beyond the minimum required (Spearman correlation = -.297, p < .001)
	Intend to stay in their unit and hospital (Spearman correlation = -.460, p < .001)
Nurses and other clinical-care providers who are confident in their ability to confront people when the concern is disrespect or abuse	Are more satisfied with their workplace (Spearman correlation = -.271, p < .001)
	Exhibit more discretionary effort—work beyond the minimum required (Spearman correlation = -.203, p < .001)
	Intend to keep their job (Spearman correlation = -.258, p < .001)

Table 6

© 2005 VitalSmarts, L.C. All Rights Reserved. VitalSmarts is a trademark and Crucial Conversations is a registered trademark of VitalSmarts, L.C.

These correlations make sense. People who feel able to confront and resolve the problems they see, take action, and improve the environment for everyone. Consider the two examples below. The first involves a physician who wasn't able to confront a peer.

> *"One surgeon actually left because of another's lousy work ethic. You'd call him at one in the morning, and he'd say, 'It can wait till morning.' The best member of his practice quit over it. No one ever made him shape up or confronted him over it. Docs would talk about it, but not to him."* (Physician)

When problems are allowed to fester, morale and productivity suffer, and patients are put at risk. Below is a contrasting example from a physician who is comfortable confronting his peer.

> *"I have a guy in my practice who is (acting in an inappropriate way) . . . It meant that his other partners and I would have to work more nights. I spoke to him. It wasn't easy but he agreed to change."* (Physician)

People who are able to speak up and address the problems they see make a positive difference. This finding isn't a big surprise. The surprise is how few healthcare workers speak up. The confident physician in the example above represents less than one in a hundred of the physicians in our sample. The other 99 percent live with their concerns and the bad outcomes they see around them.

Conclusions

The majority of the healthcare workers in this study have serious concerns about someone they work next to. Some share these concerns with coworkers and managers, but rarely speak directly to the people they are concerned about. Few of their coworkers and managers approach these people either, so the problems continue with a high frequency and for a long time.

It is critical for hospitals to create cultures of safety, where healthcare workers are able to candidly approach each other about their concerns. The added benefits in productivity improvement, reduction in nursing turnover and physician cooperation make improvement in this core competence an overwhelmingly high-leverage objective. However, it would be dangerous to conclude that the responsibility for breaking this pervasive culture of silence depends solely on making it *safer* to speak up. There are those in every hospital who are *already* speaking up, and they are not suffering for their outspokenness. Although they are only 5–15 percent of the total, they are the most effective, satisfied, and committed in the organization.

Hospitals need to learn from this skilled minority. VitalSmarts has spent 10,000 hours observing these *opinion leaders* and can recommend a series of steps for spreading their capabilities across a hospital.

© 2005 VitalSmarts, L.C. All Rights Reserved. VitalSmarts is a trademark and Crucial Conversations is a registered trademark of VitalSmarts, L.C.

Recommendations

The medical and business leaders of a hospital need to make improving crucial conversations one of their top two or three priorities for at least a year. The reluctance to confront is so deeply rooted in the healthcare culture that it will take this level of attention to create lasting improvements. The American Association of Critical-Care Nurses points out that lasting change in challenging interpersonal communication practices like these will require the combined commitment of nurses and healthcare professionals as well as healthcare organizations.[7]

Enabling crucial conversations may involve a variety of interventions, depending on the obstacles and inertia present in a hospital. Here we will focus on four steps that have provided rapid payoffs in many organizations.

Establish a Baseline and a Target for Improvement

The fundamental principle of organizational attention is: If you don't measure it you don't care about it. Survey the hospital to establish a baseline measure of the seven crucial conversations, and set a clear target for improvement.[8] A public goal for 25 percent improvement in a one-year period is achievable, and will concentrate attention on the issue. Update the baseline at least four times a year so people can be rewarded and held accountable for progress.

Conduct Focus-Group Interviews

Form interview teams that include top administrators and key physicians, and have these interview teams lead focus groups. It is important to have leaders, not staff, conduct these interviews. Leaders need to hear about the problems and their causes directly, and they need to demonstrate their willingness to listen.

The purpose of these interviews is to learn about the obstacles preventing crucial conversations. The most common obstacle you will hear is "safety;" people feel it is unsafe to confront.[9] Leaders need to take this safety concern to heart, because it is a criticism aimed at them. The interviews should solicit specific feedback about the kinds of behaviors and experiences people have that lead them to conclude they should *not* step up to these crucial conversations—or vice versa in areas where the conversations are happening.

> *"Everybody knows the cardiac surgeons can do whatever they want because they bring in a lot of dollars. I was warned not to confront them."* (Nurse)

If a cardiac surgeon is preventing nurses from confronting him or her, it is only because a manager or another physician is permitting it. These focus groups are an opportunity for leaders to learn about their role in allowing problems to continue.

© 2005 VitalSmarts, L.C. All Rights Reserved. VitalSmarts is a trademark and Crucial Conversations is a registered trademark of VitalSmarts, L.C.

Focus on Problem Areas

Use the baseline survey to focus your efforts. The survey will show you where conversations aren't happening or aren't happening well. Often, these are high-stress, high-impact areas such as the emergency room, operating rooms, and intensive care units. Focus on the intersection of "poor conversations" and "high impact."

Form teams within these problem areas, and have medical and administrative leaders participate. These teams should identify key obstacles and develop solutions to test.

Implement Training

A handful of the people in your hospital are already speaking up and resolving the problems they see around them. Training can be a powerful way to help others speak up, but its success is far from guaranteed. Below are the most critical elements in determining whether training will result in significant improvements.

- **Leaders teach.** Leaders need to conduct the training. Research shows that line managers, even those selected for their *poor* teaching abilities, achieve greater improvements than highly rated professional trainers.[10] In addition, having a leader teach a set of skills guarantees he or she will master them, and goes a long way toward ensuring he or she will "walk the talk" and model the skills.

- **Quality Materials.** The training must employ an effective instructional design. Participants need to be able to understand the concepts and master the behaviors. The skills taught should be valid in the highly emotional and risky confrontations we're asking people to step up to. Generic "communication" training will not suffice as the rules and challenges change when these seven emotionally and politically risky topics emerge. In addition, the training activities need to include emotionally compelling experiences that cause participants to examine themselves and recognize the need to change.[11]

- **Spaced learning.** Smaller chunks spaced a week or two apart are far better than longer, more intensive chunks. Two-hour or four-hour workshops avoid the cognitive overload so common in many training programs, and spaced learning allows people to apply and test the skills between sessions.

- **Sustained attention.** Some training interventions seem like a race to the finish—as if the goal were to get everyone through the course as quickly as possible. In fact, sustaining a skill-building effort over time is more important than "finishing" it on deadline. Unless people stay in the learning process for four to six months, it won't penetrate to their daily experience.

- **Relevant.** Obviously the content of the training must relate directly to risky situations people need to confront. Generic training in listening and feedback won't help participants handle the tough situations measured in our

© 2005 VitalSmarts, L.C. All Rights Reserved. VitalSmarts is a trademark and Crucial Conversations is a registered trademark of VitalSmarts, L.C.

study. Practices built into the training should focus on the specific crucial conversations the individuals involved need to master.

The problem described in this study is severe. 1) People see others make mistakes, violate rules, or demonstrate dangerous levels of incompetence 2) repeatedly 3) over long periods of time 4) in ways that hurt patient safety and employee morale 5) but they don't speak up and 6) the critical variable that determines whether they break this chain by speaking up is their confidence in their ability to confront.

These results give hospitals a powerful tool for improving patient safety and employee performance. The inability to speak up is an information bottleneck. Finding and removing the bottlenecks will release a cascade of benefits. Leaders can begin this process immediately, and achieve rapid and substantial progress.

© 2005 VitalSmarts, L.C. All Rights Reserved. VitalSmarts is a trademark and Crucial Conversations is a registered trademark of VitalSmarts, L.C.

About the Sponsors

VitalSmarts

A global leader in organizational performance and leadership, VitalSmarts provides training and consulting services to thousands of organizations, including more than 300 of the Fortune 500. For more than twenty-five years, the company principals have researched methods for bringing about systematic and lasting change. *Crucial Conversations*®, (including *The New York Times* bestselling book of the same title—McGraw-Hill 2002) delivers a set of influence tools that vitalize companies, strengthen teams, improve communities, and enrich relationships. Borrowing from more than twenty-five years of research, VitalSmarts introduces its newest *Wall Street Journal* and *New York Times* bestselling title, *Crucial Confrontations* (McGraw-Hill 2004), as well as a new set of training tools that teach organizations, teams, and individuals to effectively deal with violated expectations in a way that solves the problem at hand and strengthens the relationship in the process. VitalSmarts also offers other services including keynote speaking, on-site consulting, customized development, and executive mastery retreats.

AACN

The American Association of Critical-Care Nurses (AACN) is the world's largest specialty nursing organization. Representing the interests of more than 400,000 nurses who care for critically ill patients, AACN is dedicated to creating a healthcare system driven by the needs of patients and their families, where critical-care nurses make their optimal contribution.

AACN defines critical-care nursing as that specialty within nursing that deals with human responses to life-threatening health problems. The purpose of AACN is to promote the health and welfare of those experiencing critical illness or injury by advancing the art and science of critical care nursing and promoting environments that facilitate comprehensive professional nursing practice.

© 2005 VitalSmarts, L.C. All Rights Reserved. VitalSmarts is a trademark and Crucial Conversations is a registered trademark of VitalSmarts, L.C.

Endnotes

[1] Columbia Accident Investigation Board Report Volume 1 (August 2003) 9.

[2] L. Kohn, J. Corrigan, M. Donaldson, eds., *To Err is Human: Building a Safer Health System* (Washington, DC: National Academy Press, 2000) 127.

[3] Richard P. Wenzel and Michael B. Edmond, "The Impact of Hospital-Acquired Bloodstream Infections," Emerging Infectious Diseases 7, no. 2 (March–April 2001)

[4] HealthGrades Quality Study: *Patient Safety in American Hospitals*, (HealthGrades, Inc., July, 2004).

[5] Joint Commission on Accreditation of Healthcare Organizations, *Root Causes of Medication Errors 1995-2003.* http://www.jcaho.org/accredited+organizations/ambulatory+care/sentinel+events/rc+of+medication+errors.htm

[6] "Discretionary effort" is a concept first introduced by Daniel Yankelovich in 1983 (Yankelovich and Immerwahr, *Putting the Work Ethic to Work*, Public Agenda Foundation). It is the engine of productivity in any knowledge-intensive organization. Discretionary effort is the gap between the least amount a worker can put in without being sanctioned or fired and the most they could put in if they chose to. In many professions this "discretionary effort" can account for productivity improvements of 100–500 percent when an employee chooses to offer it.

[7] *AACN Standards for Establishing and Sustaining Healthy Work Environments: A Journey to Excellence* (American Association of Critical Care Nurses: 2005) 40.

[8] A downloadable survey of these seven crucial conversations is available at www.silencekills.com along with usage requirements.

[9] A downloadable script and suggested structure for these interviews is available at www.silencekills.com.

[10] VitalSmarts research on using leaders as teachers.

[11] For information on VitalSmarts' approach to Crucial Conversations, www.silencekills.com.

© 2005 VitalSmarts, L.C. All Rights Reserved. VitalSmarts is a trademark and Crucial Conversations is a registered trademark of VitalSmarts, L.C.