Executive summary

Claims activity:
New and paid claims drop substantially

- **New claims against medical providers fell more than 14 percent in 2003, reaching a record low.** The number of claims against physicians fell 11 percent, almost matching the lows registered in 2001, 1998 and 1997. New claims against hospitals continued a steady decline since 1991, falling 12.8 percent last year. The number of new claims provides a gauge of future costs that should affect current rates.
- **Claims closed against all providers with payment fell to the second lowest level ever – 504, compared to the all-time low of 455 in 2000.** Last year's total fell 12.5 percent from 2002.
- **Claims closed against physicians with payment fell to the second lowest level on record.** Only the 158 claims paid in 2001 were lower than the 184 last year. The 2003 total fell 20.3 percent from 2002.
- **Claims closed against hospitals with payment reached 124, or about the norm since 1998, when a steep decline began leveling out.** By contrast, paid claims against hospitals totaled 227 in 1989.

Claims payments:
Steep reductions occur in actual losses

- **Payouts to malpractice victims dropped substantially in 2003.** Insurers' overall benefits paid to malpractice victims dropped from $118.7 million to $93.5 million last year, or by 21 percent. The decline in payouts produced the lowest cash-flow ratio – the percentage of revenues actually paid in benefits – since 1994. Malpractice insurers paid out 45 cents of each premium dollar in coverage written in 2003 while unlicensed but legal surplus lines insurers paid out only 24 cents. Such low levels usually signal that rate hikes are overshooting losses as an insurance cycle peaks; normal cash-flow levels are in the 60 percent range.
- **Insurers' payouts to victims of physician malpractice dropped more steeply**, from $79.4 million to $52.9 million, or by 33 percent. The payout dropped to 39 cents for every $1 written in physicians' policies.
- **The size of average awards stayed essentially flat in 2003, rising less than 2 percent to $211,502.** The typical or median award payment in Missouri is lower -- $125,000. Average awards have stayed on a plateau since 2000, when they jumped dramatically. Average awards rose 8.1 percent last year for claims against physicians; higher economic damages for lost wages and future medical care accounted for all but $3,050 of the $18,253 increase in average 2003 awards against physicians.
- **A statistical analysis of average payments shows that the entire increase since 1990 has been accounted for by medical inflation, average wages (lost income) and the increasing severity of injuries suffered by patients.** In 1990, the average claims payment was $99,621. If wage and medical inflation and injury severity since then are considered, the expected average in 2003 would have been $209,519; instead, it was a virtually identical $211,502.

■ **The number of $1 million-plus awards remained at eight in 2003, or the usual number dating back to 1992.** The high was 11 in 1996. Three awards, all involving hospitals, exceeded $2 million last year.

■ **The growth of premiums is far outstripping actual losses**. Insurance premiums paid by physicians jumped 121 percent from 2000 ($61.4 million) to 2003 ($136.4 million), while actual payments to injured patients rose only 14 percent. All providers' malpractice insurance premiums doubled from 2000 ($113.5 million) to 2003 ($227 million). Actual payouts for claims against all providers rose more slowly during that period, from $70.6 million in 2000 to $93.5 million, or by 32 percent.

■ **The 2002 Scott decision – which created holes in Missouri's cap on noneconomic damages – continued to have a minimal impact on payouts.** That court ruling created the possibility of more than one cap per malpractice case. Insurance company lobbyists originally raised the prospect that overall losses could double or triple. However, claims reports indicated that the Scott case only affected nine cases last year that involved $3.1 million, or 1.7 percent of premiums and 3.3 percent of losses. Based on insurer evaluations, the typical case involved death, quadraplegia or severe brain damage with the need for lifetime care and/or a terminal diagnosis. In 2002, the ruling increased payments on 12 claims by $2.6 million, or 1.5 percent of premiums and 2.2 percent of total losses. The Scott decision is the only major change in how Missouri courts and insurers settle claims in almost two decades.

Estimated or incurred losses hold steady at near-record levels

■ **Insurers maintained a sharp increase in their *estimates* of what they eventually will pay for new claims, despite indicators to the contrary in 2003.** In 2001, licensed insurers in Missouri estimated future losses of $65.1 million for claims filed that year – but the total jumped to $167.9 million in 2002 and $164.3 million in 2003. (These totals also can reflect revised estimates for claims in previous years.) Insurers consequently increased their incurred loss ratio – or estimated payments on current claims as a percentage of current year's revenues – from 81 percent in 2001 to 108 percent in 2002 to 97 percent last year.

■ **Insurers' performance on physician business was much improved in 2003.** Thanks to the $26.6 million drop in actual payouts and substantial increase in premiums, the cash-flow ratio dropped to only 39 cents in payouts on the premium dollar. The incurred loss ratio, based on *estimates* of future payments, fell from 117 to 90 percent in 2003.

Injury severity

■ **The average paid claim in 2003 involved a permanent, "significant" injury such as deafness, loss of a limb or loss of an organ**, based on insurance company evaluations of the claims. The rating continues the general increase in disability for paid claims over the past 15 years. For paid claims involving physicians, the injuries were more severe.

■ **The number of deaths involved in paid claims dropped substantially from record levels in 2002.** In 2003, claims with deaths reached 166, compared to 209 the previous year, or a decline of 21 percent.

Other trends

- **After two years of steady premium hikes, health care providers began moving to unlicensed carriers, known as "surplus lines" insurers, in 2003.** These unlicensed, but legal insurance companies accounted for 18 percent of sales in 2003 versus 13 percent the prior year. Earned premium doubled from 2002 to 2003. Policyholders go to surplus lines companies when they can no longer find coverage in the regular commercial market. MDI activated a state-sponsored insurance plan in June to help provide coverage for physicians and other providers who cannot buy regular policies. But because of legal restrictions on that state-sponsored plan, only three physicians had bought its coverage through the end of September; most of the plan's business so far has involved policies for nursing facilities.
- **In inflation-adjusted dollars, gross malpractice insurance premiums for physicians now equal the level seen in 1990, although the number of practicing doctors has increased substantially.** The $121.3 million paid in 2003 compares to an inflation-adjusted $120.8 million in 1990 and $134.4 million in 1989.
- **Unlike with most insurance lines, three-fourths of malpractice claims result in a lawsuit.** The litigation percentage exceeds 81 percent for physicians.
- **Few malpractice lawsuits result in verdicts by a judge or jury.** Only 5.3 percent of all such cases reach resolution in court; the remainder result in settlements or dismissals.
- **The average victim waits 47 months, or four years, to receive an award for malpractice after the medical error occurs.** The delay is longer for cases involving physicians – 54 months, or 4½ years.

Background

The report is based upon data provided by insurers and self-insured hospitals to the Missouri Department of Insurance. The information draws on open and closed claims data that insurance companies and self-insured hospitals are required to report under Section 383.115 RSMo. The department makes every possible effort to make sure this data is accurate; however, the accuracy of this report still depends largely upon the accuracy of the data filed by the insurers and self-insured hospitals.

Additional information in Section VII was derived from the Page 15 supplement to the annual statement that companies are required to file. This section includes data for the past three years on type of business, company, volume of business, market share and loss ratios.

Data for physicians and surgeons, hospitals and other medical care providers are summarized in this report. Other medical care providers include — but are not limited to — dentists, nurses, nursing homes, chiropractors, pharmacies, optometrists, podiatrists/chiropodists, clinics and corporations.

The Missouri Medical Malpractice Insurance Report is available at the Missouri State Library and in major depository libraries in the state. Copies are available in Braille, large print or audio cassettes upon request.

Address questions on this report to the Statistics Section, Missouri Department of Insurance, P.O. Box 690, Jefferson City MO 65102-0690.