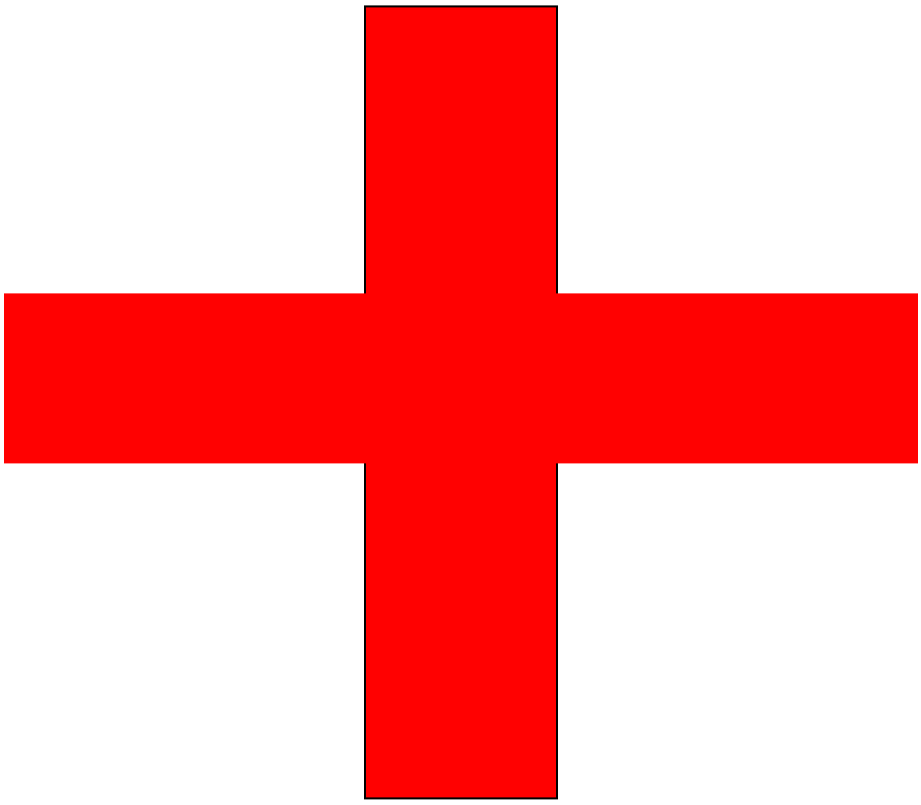
_____’s

TORT REFORM PROPAGANDA



QUICK RESPONSE KIT

The Legislator's Antidote For the Disease of *Tort Reformus Propagandas*

Instructions for use: Open only when data, facts and other truths are needed as a curative remedy for the airborne propaganda of tort reform that has been recklessly transmitted to legislators, the media and the public by those determined to take away citizens’ rights.

IT'S AN INSURANCE CYCLE: NOT A TORT CRISIS

The insurance industry and the medical lobby have been clamoring for "tort reform" ever since the latest hard market in the insurance cycle hit in 2001. A "hard market" is that part of the insurance cycle characterized by insurers suffering steep reductions in their investment profits over a short period of time, leaving them with the need to dramatically increase the premiums they charge for the policies they choose to renew and the need to either cut back in their underwriting of risks or to withdraw temporarily from the market altogether. Such underwriting cutbacks and withdrawals from a market create both an availability and an affordability problem for potential insureds until insurers' profits return to their expected heights and the market softens.

Following an unprecedented decade of insurers' investment profits during the 1990's – profits which enabled insurers to consistently under-charge doctors and hospitals for malpractice coverage in order to garner greater market share, insurers' investment profits plummeted all over the country, including in Georgia, in late 2000 and throughout 2001 and 2002.

In response to these significant investment shortcomings, insurers sharply increased the premiums they charge doctors and hospitals, dramatically restricted their underwriting of risks and, in many cases, temporarily withdrew from the medical malpractice insurance market altogether, until a time when the investment markets begin producing more significant profits for the insurance industry. This is the inevitable, natural essence of the hard market segment of the insurance cycle.

Just like during the hard markets of the 1970's and 1980's, insurance companies have raised premiums in this hard market and have managed to convince many of their policyholders that lawsuits are the cause of the premium increases and that "tort reform" will reduce their insurance premiums. Many states have succumbed to these deceiving arguments and have enacted caps on damages that injured plaintiffs can recover. Georgia has wisely resisted these calls and is now in a position to evaluate whether the "reforms" enacted in other states have resulted in premium reductions for doctors and hospitals.

The data is in, and the conclusion is clear: Tort reform has NOT led to premium reductions.

OTHER STATES' EXPERIENCES WITH CAPPING DAMAGES

Nationwide. In an article entitled "Caps Disappoint," the *Atlanta Business Chronicle* reported on a newly released study by Weiss Ratings, Inc., a national, independent ratings provider for financial services companies, insurers and investment companies. In the article, the *ABC* stated that the Weiss Study found that caps on non-economic damages failed to prevent sharp increases in medical malpractice insurance premiums, even though insurers enjoyed a slowdown in payouts. The Weiss report reviewed the impact of tort reform on malpractice premiums over a 10-year period and found that in all but two of the 19 states where caps were passed, doctors continued to experience premium increases. "**Caps Disappoint**," *Atlanta Business Chronicle*, June 6, 2003.

Colorado. Despite Colorado's having caps on non-economic damages and one of the most restrictive tort reform laws in the country, including the passage of a 2003 amendment making it clear that Colorado's non-economic damages cap also limits claims for physical impairment and disfigurement, the doctors of Colorado learned that their malpractice premiums would continue to climb in 2004. COPIC Insurance, the insurer of about 80% of the doctors who buy private insurance in Colorado, pushed for the 2003 changes, saying it was necessary to keep down the costs of medical malpractice insurance. However, COPIC announced in November of 2003 that it would raise its doctors' malpractice premiums an average of 13.8 percent for 2004. This premium hike comes on the heels of an average premium increase in 2003 of 14%. "**Colorado doctors brace to pay more***,"* *Denver Business Journal*, November 3, 2003.

Florida. In August of 2003, the Florida legislature passed caps on non-economic damages in medical malpractice lawsuits, "claiming it would put a lid on spiraling malpractice insurance rates." So far, "doctors have yet to see any changes." In fact, medical malpractice insurance companies in Florida filed rate hike requests in the Fall of 2003 – only months after the insurers lobbied the legislature for the caps on damages and other tort reform measures -- seeking 15 to 20% increases in the premiums they wanted to charge their policyholder doctors. As for whether caps on damages would ever have any significant impact on the rates insurers charge doctors, a spokesman for Florida's insurance industry conceded that it could take years for that to happen. "We said all along caps would not provide immediate savings," said Sam Miller, vice president for public affairs and communication with the Florida Insurance Council in Tallahassee**. "Legislature Fails to Defuse Med-Mal Crisis**," The Business Journal – Tampa Bay, November 13, 2003.

Texas. In the summer of 2003, many Texas doctors lobbied their patients to vote for Proposition 12, a constitutional amendment that would ex post facto approve the Texas legislature's decision to cap the damages that can be awarded in medical malpractice lawsuits. Some of those patients – and doctors – may now be asking what Texas homeowners have asked for years: Where are the promised lower insurance premiums?

Despite wild predictions and promises that the doctors' premiums would come down if Proposition 12 were to be adopted by the people of Texas, the Houston Chronicle reported on November 19, 2003, that "two of the [state's] five major carriers are planning to increase rates for physicians." GE Medical Protective, one of the five carriers that collectively insures more than 2/3 of all Texas physicians, sought to raise its rates 19 percent beginning in June and the state's Joint Underwriting Association asked for 35 percent higher rates beginning in January. "**Doctors now learning what average homeowners know well**," San Antonio Express-News, November 23, 2003.

West Virginia. It may be too early to breathe a sigh of relief and declare the medical malpractice insurance crisis over in West Virginia. There are disturbing indications that hurdles remain to be cleared. Legislation passed earlier this year to make medical malpractice insurance more affordable for health care professionals still hasn't kicked in fully, to judge by recent reports. Last week, for example, the state Board of Risk Insurance Management revealed it will be increasing malpractice insurance rates by 8.4 percent for the first six months of next year. The BRIM plan covers nearly 1,300 doctors who have had trouble obtaining insurance through private carriers.

But in the private sector, matters are even more worrisome. The only other large provider of malpractice insurance in West Virginia, Medical Assurance, plans to increase rates by 13 percent. "Clearly, rate increases in that range aren't what state legislators had in mind when they approved malpractice reform measures**. "Medical Malpractice Still Problem in W. Va.**," *The Intelligencer – Wheeling News-Register*, November 22, 2003.

Indiana. Indiana physicians who have enjoyed a friendly medical liability climate got blindsided when they received, on short notice, word of a 72.6% increase in what they pay into a state fund that compensates patients injured by medical malpractice. Indiana, which has a cap on non-economic damages, is one of only six states the AMA says is not in the throes, or showing warning signs, of a medical liability insurance crisis. The 72.6% increase, announced last month, was the first increase in several years. Doctors, who pushed for legislation in the late 1990s to make sure the fund was audited regularly, want to see that audits are done on a more regular basis. "**Indiana doctors face big hit for liability fund**," *AMNews*, September 8, 2003.

Mississippi. Hospital officials in Jackson, MS acknowledged that the passage of medical malpractice reforms by the state legislature in October of 2002 would not mean that the availability or the cost of malpractice insurance would change any time soon. Greenwood Leflore Hospital's Executive Director, Bob Barrett, said, "What I hope personally is that this will stabilize the increases. I don't think it is going to cause insurance rates to go down**." "New medical malpractice law will not help hospital anytime soon,"** *Greenwood Commonwealth*, October 13, 2002.

Nevada. After being subjected to a nasty campaign by insurers and organized medicine during the summer of 2002, including the deliberate closing of trauma centers, in order to strong-arm the

legislature into enacting severe caps on medical malpractice compensation, the Nevada legislature passed significant "tort reform" measures, including a cap on damages in malpractice cases. Insurance groups fought any attempt to add a provision to guarantee lower rates should the legislation pass. Within weeks of the law's enactment, the insurance industry proclaimed that they would not reduce insurance rates. **"Insurer has no plans to lower costs in Las Vegas,"** *Associated Press*, August 10, 2002.

Oklahoma. Despite the fact that the Oklahoma legislature has adopted caps on non-economic damages for emergency room and OB/GYN cases, Oklahoma's largest provider of medical-liability insurance has received permission for a cumulative rate increase of 83% over the next three years.

The Oklahoma State Medical Association, which owns the Physicians Liability Insurance Cos. (PLICO), requested the staggering rate increase and then applauded the state's insurance commissioner for spreading the increase over the next 3 years, stating "We physicians are deeply indebted to you for allowing us to spread the increase in malpractice insurance premium over the next three years." **"Oklahoma's Largest Medical-Liability Company Gets 83% Rate Increase Over Three Years,"** *BestWire Services*, December 3, 2003.

THE REPEATING PATTERN:
STATES ENACT CAPS AND INSURERS RAISE RATES

GEORGIA MUST NOT BUY INTO THIS FRAUD

COMPARING
PREMIUMS IN CAP STATES
TO
PREMIUMS IN NON-CAP STATES

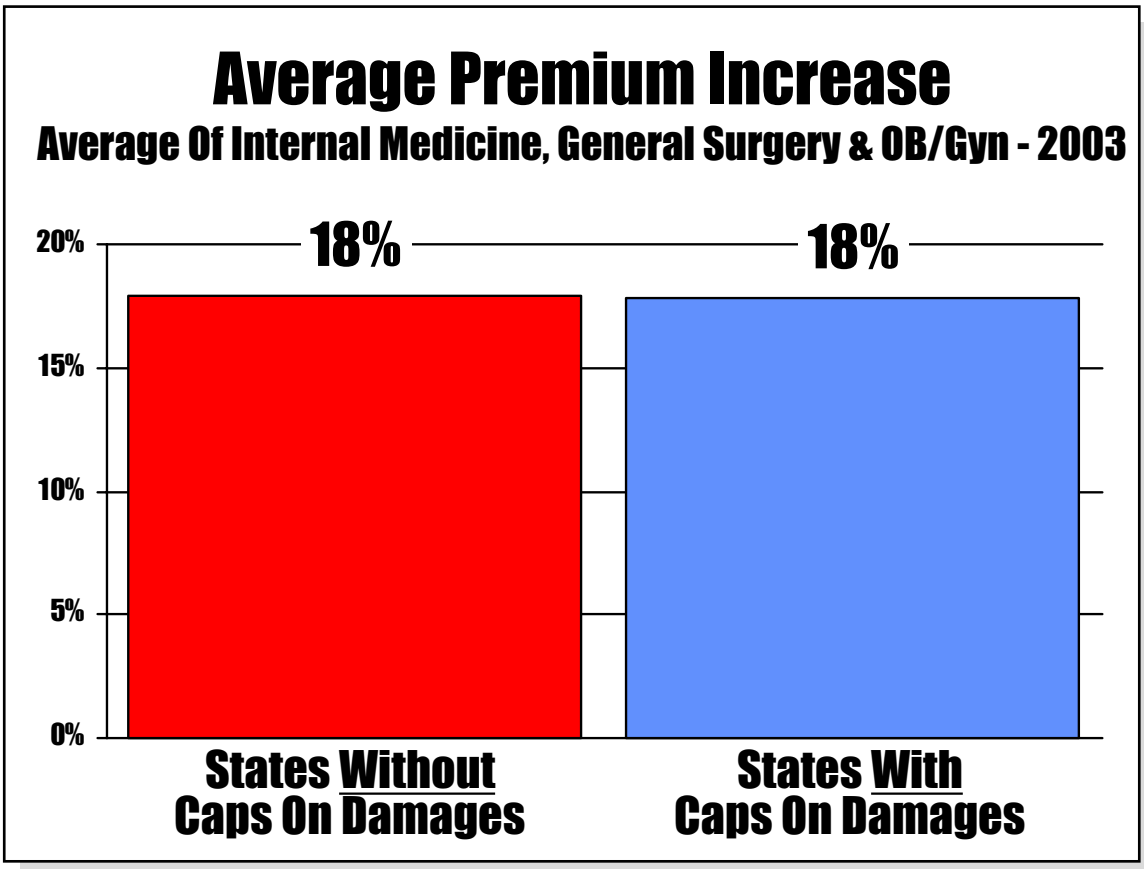
Physicians across a broad array of specialties actually pay **MORE** in premiums in states that cap damages than in states that do not cap damages. As the charts on the following pages demonstrate, the average liability premium for internists, surgeons, and OB/GYNs is **HIGHER** in states **WITH CAPS** than in states without caps.

If capping damages reduced premiums, why do these physicians in cap states pay so much more?

The answer is clear: capping damages does not reduce premiums.

Medical Malpractice

Do Caps Prevent Large Premium Increases?

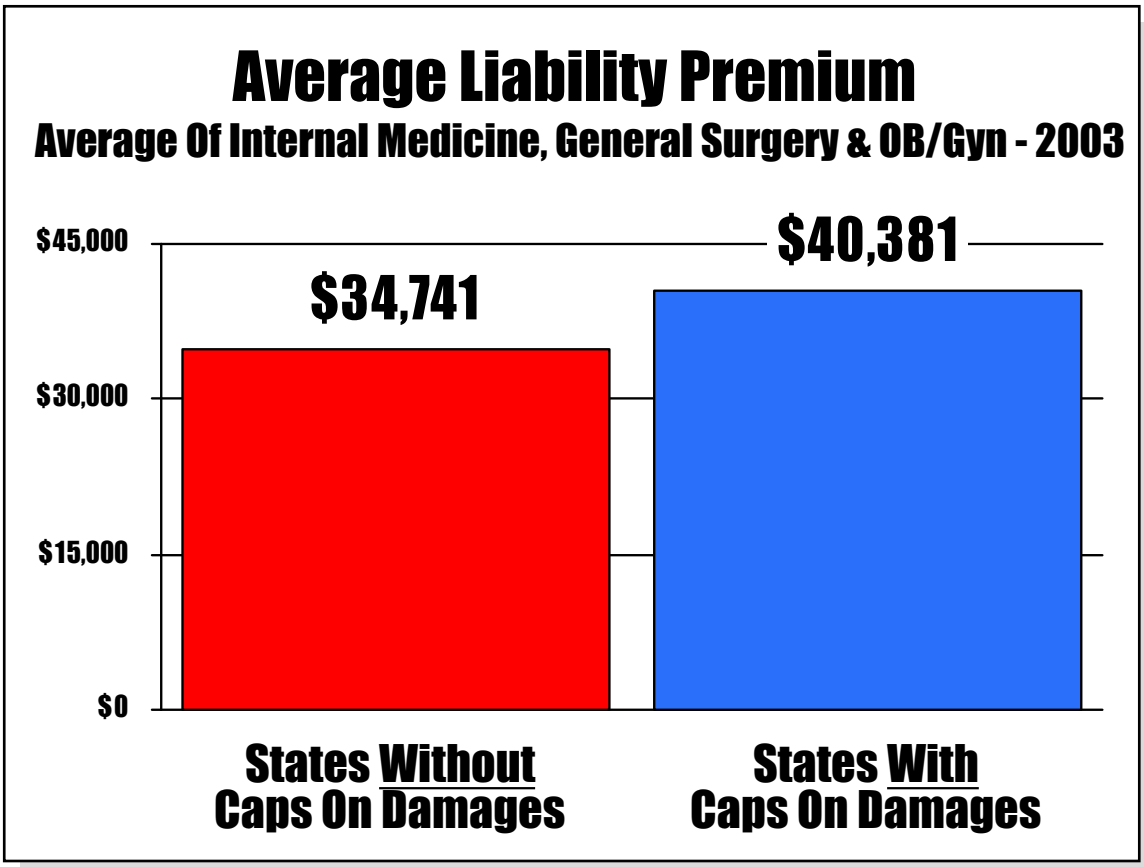


- **Premium Increases In States With And Without Malpractice Caps Were The Same Last Year**
- **Caps Do Not Prevent Large Premium Increases**
- **Deterring Malpractice Is The Best Way To Bring Down Costs & Protect Our Families**

Derived from data provided by Medical Liability Monitor (Oct 2003) A state's average premium is calculate as the unweighted mean value of premiums for all companies for which data is provided across all regions. The following states are classified as having caps that affect medical malpractice cases broadly: AK, CA, CO, FL, HI, ID, IN, KS, LA, MD, MA, MI, MS, MO, MT, NE, NV, NM, ND, OH, SD, TX, UT, VA, WV, WI. Maine and New Jersey are excluded because their caps only affect cases or wrongful death. Oklahoma is excluded because its cap only affects emergency room and pregnancy-related care.

Medical Malpractice Insurance

Do Caps Reduce Malpractice Premiums?



- **Premiums Averaged Across Specialties Are 16.2% Higher In States With Damage Caps**
- **Caps Do Not Bring Down Malpractice Premiums**
- **Deterring Malpractice Is The Best Way To Bring Down Costs & Protect Our Families**

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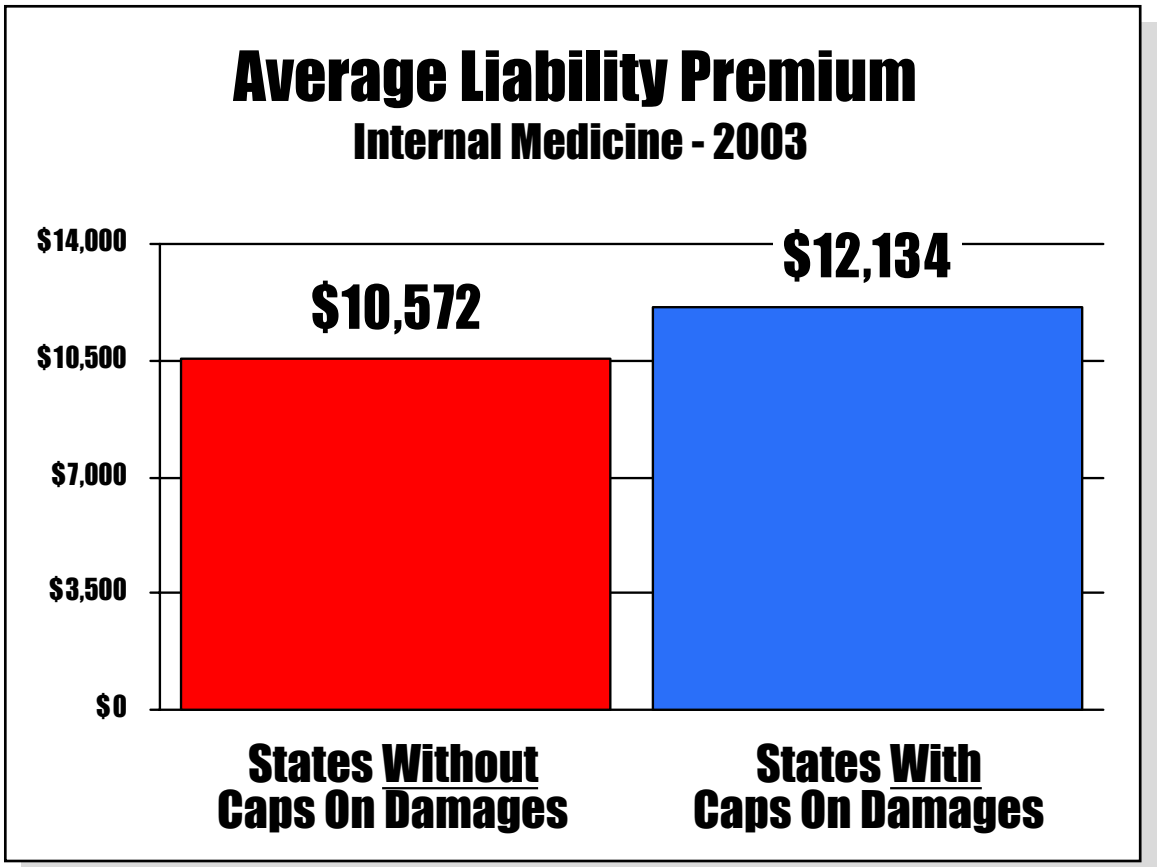
Medical Malpractice Insurance

Do Caps Reduce Malpractice Premiums?

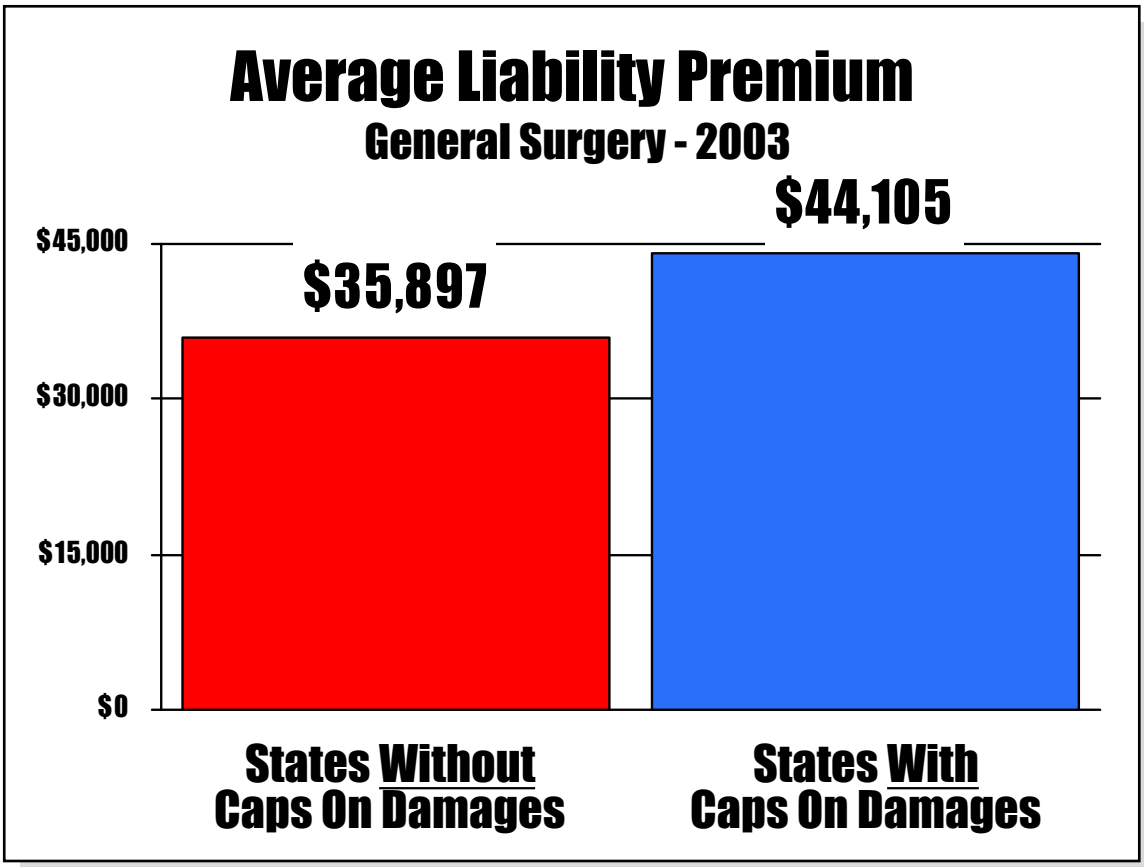


- **Premiums For Doctors Of Internal Medicine Are 14.7% Higher In States With Caps On Damages**
- **Caps Do Not Bring Down Malpractice Premiums**
- **Deterring Malpractice Is The Best Way To Bring Down Costs & Protect Our Families**

Derived from data provided by Medical Liability Monitor (Oct 2003) A state's average premium is calculate as the unweighted mean value of premiums for all companies for which data is provided across all regions. The following states are classified as having caps that affect medical malpractice cases broadly: AK, CA, CO, FL, HI, ID, IN, KS, LA, MD, MA, MI, MS, MO, MT, NE, NV, NM, ND, OH, SD, TX, UT, VA, WV, WI. Maine and New Jersey are excluded because their caps only affect cases of wrongful death. Oklahoma is excluded because its cap only affects emergency room and pregnancy-related care.

Medical Malpractice Insurance

Do Caps Reduce Malpractice Premiums?

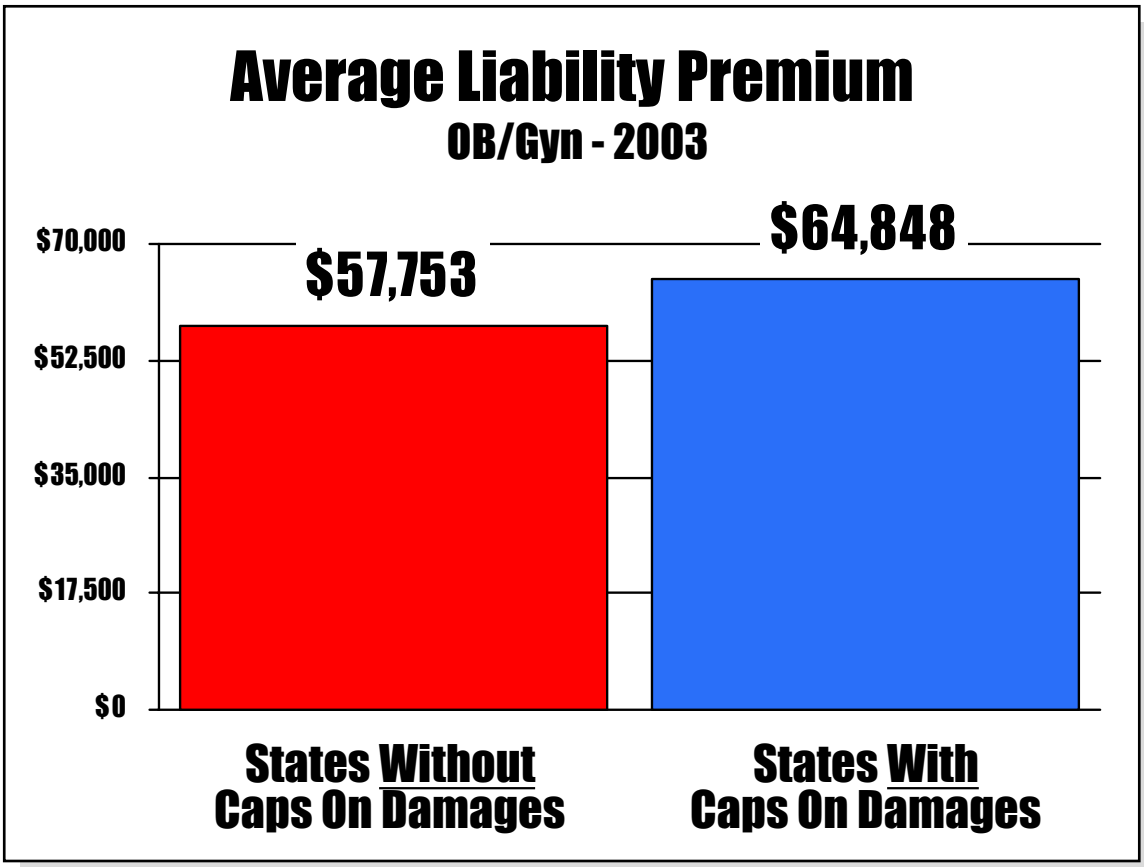


- **Premiums For General Surgeons Are 22.9% Higher In States With Caps On Damages**
- **Caps Do Not Bring Down Malpractice Premiums**
- **Deterring Malpractice Is The Best Way To Bring Down Costs & Protect Our Families**

Derived from data provided by Medical Liability Monitor (Oct 2003) A state's average premium is calculate as the unweighted mean value of premiums for all companies for which data is provided across all regions. The following states are classified as having caps that affect medical malpractice cases broadly: AK, CA, CO, FL, HI, ID, IN, KS, LA, MD, MA, MI, MS, MO, MT, NE, NV, NM, ND, OH, SD, TX, UT, VA, WV, WI. Maine and New Jersey are excluded because their caps only affect cases of wrongful death. Oklahoma is excluded because its cap only affects emergency room and pregnancy-related care.

Medical Malpractice Insurance

Do Caps Reduce Malpractice Premiums?



- **Malpractice Premiums For OB/Gyns Are 12.3% Higher In States With Caps On Damages**
- **Caps Do Not Bring Down Malpractice Premiums**
- **Deterring Malpractice Is The Best Way To Bring Down Costs & Protect Our Families**

Derived from data provided by Medical Liability Monitor (Oct 2003) A state's average premium is calculate as the unweighted mean value of premiums for all companies for which data is provided across all regions. The following states are classified as having caps that affect medical malpractice cases broadly: AK, CA, CO, FL, HI, ID, IN, KS, LA, MD, MA, MI, MS, MO, MT, NE, NV, NM, ND, OH, SD, TX, UT, VA, WV, WI. Maine and New Jersey are excluded because their caps only affect cases of wrongful death. Oklahoma is excluded because its cap only affects emergency room and pregnancy-related care.

A LOOK AT ALL FIFTY STATES

If damages caps reduce premiums, we would expect to see lower average premiums in states with damage caps than in states without damage caps. Instead, the following chart of all 50 states demonstrates that there is absolutely no correlation between a state having caps on damages and the likelihood of that state having lower premiums. Indeed, states with caps have the highest average premium of any state in the nation (Florida) and the lowest average premium (South Dakota). Half of the cap states are above the national median, and half are below it. Similarly, half the non-cap states are above the national median and half are below it – including Georgia. Caps do not reduce premiums.

There are 14 Cap States that have average medical malpractice insurance premiums above the national median premium and there are 11 Cap States that have average medical malpractice insurance premiums below the national median premium.

There are 11 Non-Cap States that have average medical malpractice insurance premiums above the national median premium and there are 14 Non-Cap States that have average medical malpractice insurance premiums below the national median premium.

If you were to follow the tort reformists' premise that the presence or absence of caps on damages was THE deciding factor as to whether premiums would be high or low, the FACTS in the following chart would dictate a conclusion that it was the ABSENCE of caps that leads to lower premiums.

The simple fact is that a majority of the states whose average premiums are BELOW the national median premium DO NOT HAVE CAPS ON DAMAGES.

Premiums And Damage Caps

States In Gray Have Caps Affecting Noneconomic Damages: 2003

State	Average Premium
Florida	$123,769
Illinois	$69,424
Pennsylvania	$68,160
Michigan	$65,596
Texas	$61,930
Ohio	$59,094
District of	$58,404
Nevada	$58,075
West Virginia	$55,790
Connecticut	$54,561
New York	$50,545
Massachusetts	$49,659
Missouri	$49,633
New Jersey	$48,751
New Mexico	$46,381
Louisiana	$43,864
Maryland	$43,311
Utah	$39,333
Arizona	$38,615
Wyoming	$38,609
Montana	$37,327
Colorado	$36,003
Rhode Island	$35,931
North Carolina	$35,931
Kentucky	$34,765
California	$33,433
Mississippi	$33,080
Alaska	$32,617
Delaware	$32,085
Hawaii	$31,592
New Hampshire	$30,493
Virginia	$29,870
Washington	$29,049
Georgia	$28,814
Tennessee	$28,519
Oregon	$27,466
Alabama	$26,579
South Carolina	$25,019
Kansas	$24,385
Indiana	$23,565
Vermont	$21,339
Arkansas	$20,680
Maine	$19,930
Iowa	$18,829
Wisconsin	$16,898
Idaho	$16,341
North Dakota	$16,311
Oklahoma	$14,454
Minnesota	$11,567
Nebraska	$11,153
South Dakota	$10,899

Specialty	Average Premium
Across Specialties	$37,616
Internists	$11,368
General Surgery	$40,082
OB/Gyn	$61,370

14 Cap States Above the Median
11 Noncap States Above the Median
11 Cap States Below the Median
14 Noncap States Below the Median

Derived from data provided by Medical Liability Monitor (Oct 2003) A state's average premium is calculate as the unweighted mean value of premiums for all companies for which data is provided across all regions. The following states are classified as having caps that affect medical malpractice cases broadly: AK, CA, CO, FL, HI, ID, IN, KS, LA, MD, MA, MI, MS, MO, MT, NE, NV, NM, ND, OH, SD, TX, UT, VA, WV, WI. Maine and New Jersey are excluded because their caps only affect cases or wrongful death. Oklahoma is excluded because its cap only affects emergency room and pregnancy-related care.

A LOOK AT THE SOUTHEAST

Tort reformists argue that Georgia is – or supposedly will be – at a disadvantage in competing for doctors because some of our neighbors in the southeastern region of the country have passed caps and Georgia has not. Is there any truth to this argument? For this argument to be accurate, the presence of caps on damages in a state would have to show a resulting lower set of premiums and the absence of caps would need to show a resulting set of higher premiums.

Unfortunately for the tort reformists – but fortunately for Georgia and Georgia's physicians – the following chart shows that there is no correlation between the presence of caps on damages in a Southeastern state and the likelihood that the Southeastern state will have lower average premiums. Likewise, there is no correlation between the absence of caps on damages in a Southeastern state and the presence of higher average premiums. Again, there simply is no correlation between capping damages and lowering malpractice premiums. In fact, 5 of the 7 Southeastern States at or above the national median premium have caps on damages. 5 of the 6 Southeastern States below the national median premium DO NOT have caps on damages.

If capping damages were the key to bringing about lower premiums, wouldn't the states that have adopted caps have the lowest premiums?

If failing to cap damages were the cause of higher premiums, wouldn't the states without caps on damages have the most expensive premiums?

The answer to these questions is made clear in the following chart: Capping damages simply does not lead to lower medical malpractice insurance premiums.

COMPARING SOUTHERN STATES

Do Caps on Damages Have Any Impact on Premiums?

State	Average Premium	Cap on Non-Economic Damages (Caps are shown in gray)
Florida	**$123,769**	**$500,000 Cap on Non-economic damages. [Highest premiums in the nation]**
West Virginia	**$55,790**	**$1M Non-Economic Damages**
Kentucky	**$34,765**	**NONE**
Louisiana	**$43,864**	**$500,000 Overall Cap excluding future Medicals (considered "strongest" or "most draconian" cap on damages in the nation).**
North Carolina	**$35,931**	**NONE**
Maryland	**$43,311**	**$605,000 Cap on Non-Economic**
Mississippi	**$33,080**	**$500,000 Cap on Non-Economic**
National Median and Related Statistics	**$33,080**	**28 States Have Caps – 22 Do Not Have Caps: 14 States Above Median Premium Have Caps; 11 States Above Median Do NOT Have Caps; 14 States At/Below the Median Have Caps; 11 States At/Below Median Do NOT Have Caps**
Tennessee	**$28,519**	**NONE**
Georgia	**$28,814**	**NONE**
Alabama	**$26,579**	**NONE**
Virginia	**$29,870**	**$1.6M Overall Cap (All Damages)**
South Carolina	**$25,019**	**NONE**
Arkansas	**$20,680**	**NONE**

5 of the 7 Southern States at or ABOVE the national median premium HAVE CAPS on damages. 5 of the 6 Southern States BELOW the national median premium DO NOT have caps on damages.

*Chart derived from data provided by Medical Liability Monitor (Oct 2003). A state's average premium is calculated as the un-weighted mean value of premiums for all companies for which data is provided across all regions.

INDEPENDENT WEISS RATINGS STUDY

A comprehensive study conducted by Weiss Ratings, an independent insurance and investment companies analyst, revealed that from 1991 to 2002 the median premium rose FASTER in states WITH CAPS than in states without caps.[1] Weiss ratings summarize the results of its study as follows:

> In short, the results clearly invalidate the expectations of cap proponents. To review the surprising facts:
>
> · Insurers in states with caps raise 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 continue to raise rates, while insurers in states without caps were actually *more* likely to hold or cut their premium rates.
>
> · Insurers in states with caps are more likely to charge medmal premiums *exceeding the national median* than insurers in states without caps.[2]

[1] Medical Malpractice Caps: The Impact of Non-economic Damage Caps on Physician Premiums, Claims Pay-out Levels and Availability of Coverage, Weiss Ratings, Inc. June 2, 2003.

[2] Weiss Ratings Study, p.8.

ADMISSIONS BY INSURERS AND THEIR LOBBYISTS

Honest insurers and lobbyists admit that tort reform will not reduce malpractice premiums. The American Insurance Association (AIA) said that lawmakers who enact "tort reform" should not expect insurance rates to drop. Specifically, a March 13, 2002, AIA press release leads with an astounding pronouncement:

- **"[T]he insurance industry never promised that tort reform would achieve specific premium savings."**

Donald J. Zuck, Chief Executive of Scpie Holdings, Inc., a leading malpractice insurer in California, told the Wall Street Journal:

- **"I don't like to hear insurance-company executives say it's the tort system -- it's self-inflicted."**[3]

In the current debate, no insurance spokesperson will agree to premium reductions if damages caps are instituted. Indeed, they acknowledge damages caps won't reduce premiums. American Tort Reform Association (ATRA) President Sherman Joyce told Liability Week that:

- "**we wouldn't tell you or anyone that the reason to pass tort reform would be to reduce insurance rates**."[4]

And, according to Victor Schwartz, General Counsel of ATRA:

- **"many tort reform advocates do not contend that restricting litigation will lower insurance rates, and I've never said that in 30 years."**[5]

The Center for Justice & Democracy recently completed an exhaustive study of the relationship between "tort reform" and malpractice premiums. They concluded that "**tort reform" has historically had no impact on insurance rates**.[6]

Locally, John Henry, CEO of Emory Hospitals, including Emory University Hospital and Crawford Long Hospital told the Atlanta Business Chronicle that:

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[3] Wall Street Journal, June 24, 2002.

[4] Liability Week, July 19, 1999.

[5] Business Insurance, July 19, 1999.

[6] Premium Deceit – The Failure of 'tort reform' to Cut Insurance Prices. J. Robert Hunter, former Commissioner of Insurance in Texas and Joanne Doroshow, Executive Director for Justice & Democracy.

- "what is happening to us is more than just malpractice insurance. Directors' and officers' liability insurance has gone through the roof, insurance on buildings has gone up. **There does not seem to be any direct relationship between claims and premium increases; it seems more related to Sept. 11 and the need for insurance companies to generate profits for shareholders."**[7]

According to the Wall Street Journal, "[s]ome doctors are beginning to acknowledge that the conventional focus on jury awards deflects attention from the insurance industry's behavior. The American College of Obstetricians and Gynecologists, for the first time is conceding that carrier's business practices have contributed to the current problem, says Alice Kirkman, a spokesperson for the professional group:

- **[W]e are admitting it's much more of a complex problem than we have previously talked about," she says**.[8]

Following the enactment of extensive "tort reforms" in Florida in 1986, insurers were required to indicate in their subsequent filings their predictions of what savings would result from the passage of the 1986 tort reform package. Out of 277 filings by 104 insurers, 63 percent of them said there would be no savings from the tort reform package and none predicted savings of more than 10 percent. 9

In fact, after Florida passed its 1986 reforms, St. Paul Insurance Company conducted a study on all of its 1983 and 1984 claims to determine what effect the passed tort reform measures [including a cap on damages and other measures] would have had on those claims if the law had already been in effect. Here was St. Paul's conclusion:

The tort law changes effective July 1, 1986 in Florida will, hopefully, have a positive impact on loss costs for occurrences after that date. However, to forecast the effect is highly speculative. Our evaluation of prior losses showed little or no savings under key provisions of the law and our analysis of other previsions show no expected savings. Our best estimate is no effect from the tort changes. 10

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[7] Atlanta Business Chronicle, March 28, 2002, p.36A

[8] Wall Street Journal, June 24, 2002.

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

10 St. Paul filing, State of Florida Department of Insurance, 1986.

Modern Physician Rates Best Places to Practice Medicine: Survey Sheds Light on Fallacy of AMA Claims

Modern Physician, one of the leading publications for physicians in America, conducted a study to determine where the best communities for running a medical practice are found in this country. Those conducting the study considered a number of relevant factors including the cost of medical malpractice insurance in the medical community, the rate of population growth in the community, the rate of managed care penetration in the community, etc., etc. The results of this research were published in October of 2003.

As the following information demonstrates, an interesting comparison exists between the **factual findings of *Modern Physician*** and the anecdotally driven **claims of the AMA** and other medical organizations that are determined to pass tort reform legislation in the U.S. Congress and the Georgia General Assembly.

- **46 of the "best communities" are in states that do not have caps on damages**;
- Only 26 of the "best communities" are in states that have caps on damages;
- 3 of the communities span borders between cap and non-cap states;
- **None of the top 30 communities are from California** where MICRA, the model for capping damages and other tort reform legislation under consideration by the Congress and many state legislatures, including Georgia's, is the law.

Conclusion No. 1: Caps on damages do not make communities more attractive for running medical practices and the absence of caps does not take away from the attractiveness of communities for running medical practices. In short, a decision NOT to cap damages does NOT "threaten access to care."

10 out of the top 20 best places to practice medicine are in states identified by the AMA as "crisis states," including the top spot in the country, ATHENS, GEORGIA!! The other 10 of the top 20 best places are in states "showing problems." None of the top 20 best places to practice medicine are in states listed by the AMA as "currently okay."

Conclusion No. 3: The AMA's categorizations are meaningless and politically motivated.

GEORGIA communities found by *Modern Physician* to be among the Top 75 communities for running a medical practice in America:

- **ATHENS, Georgia:** **NO. 1 COMMUNITY IN THE NATION**
- ATLANTA, Georgia: No. 11 community in the nation
- **SAVANNAH, Georgia:** **No. 63 community in the nation**

Not bad for a state considered by the AMA and MAG to be among the 12 states most "in crisis" because of the cost of medical malpractice insurance coverage.

The LIST

Criteria used for determining our best places ranking:

Population change: Change of population from 1990 to 2000 for 354 metropolitan areas. From U.S. Census Bureau.

Malpractice premiums: Premium level for internal medicine, no surgery, for a claims-made policy at a coverage level of $1 million per claim, $3 million per year, for 89 states or localities, as of September 2002. From Medical Liability Monitor.

Medicare reimbursement level: Medicare reimbursement for a mid-level office visit, CPT Code 99213, for 89 state or localities in 2003. From CMS.

Labor costs: Hourly mean payment for healthcare support occupations for 336 metropolitan areas in 2001, from occupational employment and wage estimates. From Bureau of Labor Statistics.

State income tax. Income tax levels for 50 states, District of Columbia and Puerto Rico as of 2003. From Federation of Tax Administrators.

Education attainment: Percent of population ages 25 to 34 years with a college degree in year 2000, for 356 metropolitan areas. From U.S. Census Bureau.

Criteria ranked by ordinals; lowest score ranks best.

Our top 75 places to run a medical practice

Rank	Community	Total weighted score	Rank	Community	Total weighted score
1	Athens, Ga. MSA	832.38	39	Oklahoma City, Okla. MSA	1,315.56
2	Charlottesville, Va. MSA	853.22	40	Jonesboro, Ark. MSA	1,322.04
3	Auburn-Opelika, Ala. MSA	864.62	41	Rapid City, S.D. MSA	1,322.04
4	Bryan-College Station, Texas MSA	911.82	42	Aguadilla, Puerto Rico MSA	1,322.30
5	Sioux Falls, S.D. MSA	974.04	43	Montgomery, Ala. MSA	1,326.62
6	Huntsville, Ala. MSA	1,024.62	44	Portland-Vancouver, Ore.-Wash. PMSA	1,337.32
7	Nashville, Tenn. MSA	1,067.68	45	Orange County, Calif. PMSA	1,350.26
8	Bellingham, Wash. MSA	1,087.20	46	Clarksville-Hopkinsville, Tenn.-Ky. MSA	1,351.68
9	Raleigh-Durham-Chapel Hill, N.C. MSA	1,105.58	47	Boulder-Longmont, Colo. PMSA	1,352.00
10	Lawrence, Kan. MSA	1,112.38	48	Colorado Springs, Colo. MSA	1,354.00
11	Atlanta, Ga. MSA	1,113.84	49	Oakland, Calif. PMSA	1,356.24
12	Wilmington, N.C. MSA	1,127.58	50	Boise City, Idaho MSA	1,358.00
13	Olympia, Wash. PMSA	1,137.20	51	Bismarck, N.D. MSA	1,365.34
14	Provo-Orem, Utah MSA	1,154.18	52	Norfolk-Virginia Beach-Newport News, Va.-N.C. MSA	1,366.34
15	Richmond-Petersburg, Va. MSA	1,158.10	53	Springfield, Mo. MSA	1,370.24
16	Fayetteville-Springdale-Rogers, Ark. MSA	1,162.04	54	Bloomington, Ind. MSA	1,378.84
17	Greenville, N.C. MSA	1,173.58	55	Charlotte-Gastonia-Rock Hill, N.C.-S.C. MSA	1,379.58
18	Fort Worth-Arlington, Texas PMSA	1,174.26	56	Anchorage, Alaska MSA	1,382.32
19	Knoxville, Tenn. MSA	1,177.68	57	Salt Lake City-Ogden, Utah MSA	1,388.18
20	Jackson, Tenn. MSA	1,179.68	58	Wilmington-Newark, Del.-Md. PMSA	1,388.26
21	Columbia, Mo. MSA	1,204.24	59	Caguas, Puerto Rico PMSA	1,392.30
22	Fort Collins-Loveland, Colo. MSA	1,208.00	60	Tallahassee, Fla. MSA	1,396.42
23	Brazoria, Texas PMSA	1,210.72	61	Missoula, Mont. MSA	1,396.80
24	Austin-San Marcos, Texas MSA	1,215.82	62	Tulsa, Okla. MSA	1,397.56
25	Fargo-Moorhead, N.D.-Minn. MSA	1,217.34	63	Savannah, Ga. MSA	1,399.78
26	Lincoln, Neb. MSA	1,231.50	64	San Juan-Bayamon, Puerto Rico PMSA	1,404.30
27	Hattiesburg, Miss. MSA	1,239.18	65	Orlando, Fla. MSA	1,406.42
28	Houston PMSA	1,239.36	66	Minneapolis-St. Paul, Minn.-Wis. MSA	1,415.28
29	Galveston-Texas City, Texas PMSA	1,262.30	67	Barnstable-Yarmouth, Mass. MSA	1,415.72
30	Seattle-Bellevue-Everett, Wash. PMSA	1,263.20	68	Denver, Colo. PMSA	1,416.00
31	Yolo, Calif. PMSA	1,264.46	69	Laredo, Texas MSA	1,419.82
32	Richland-Kennewick-Pasco, Wash. MSA	1,279.20	70	Tuscaloosa, Ala. MSA	1,424.62
33	Nashua, N.H. PMSA	1,280.60	71	Corvallis, Ore. MSA	1,425.32
34	Dallas, PMSA	1,282.36	72	Manchester, N.H. PMSA	1,427.76
35	Jackson, Miss. MSA	1,287.18	73	Arecibo, Puerto Rico PMSA	1,436.30
36	Bremerton, Wash. PMSA	1,293.20	74	Portsmouth-Rochester, N.H.-Maine PMSA	1,436.60
37	Flagstaff, Ariz.-Utah MSA	1,293.66	75	Columbia, S.C. MSA	1,438.04
38	Little Rock-North Little Rock, Ark. MSA	1,300.04			

Medical Malpractice

Does Being In "Crisis" Mean Anything?

Best Places To Practice Medicine

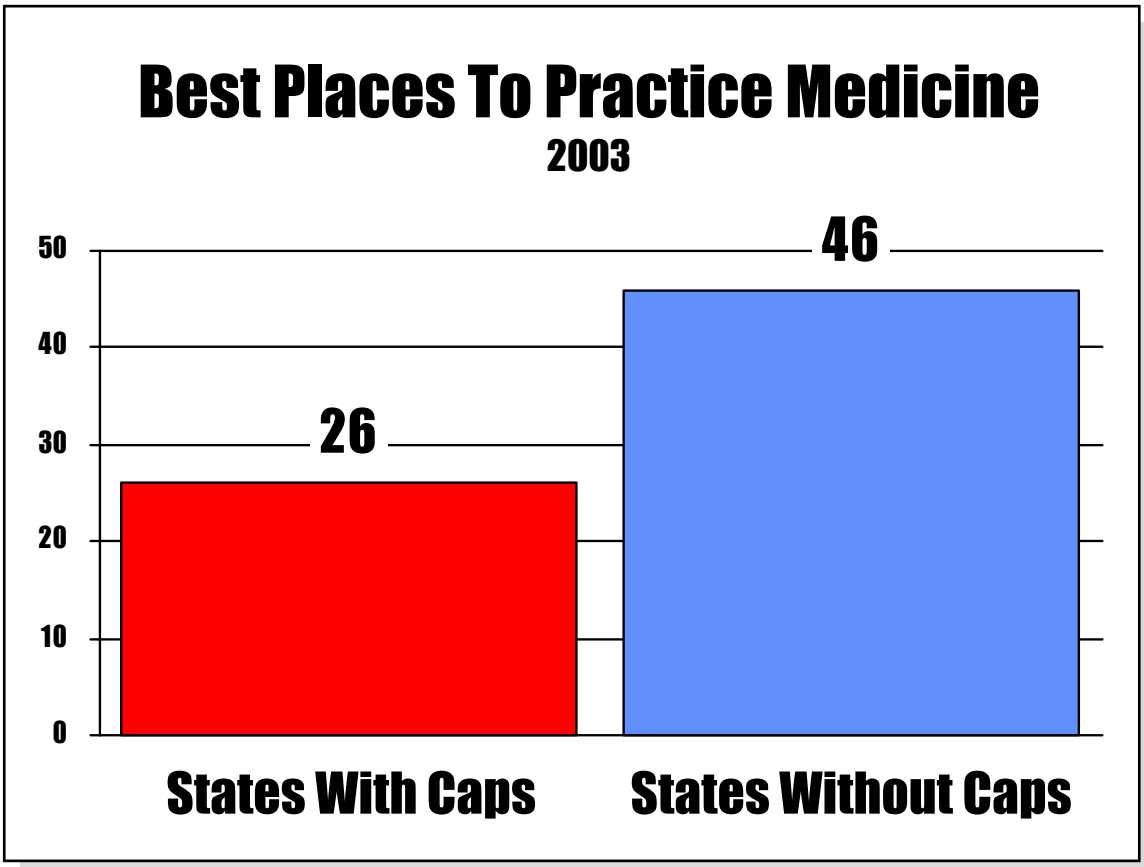
Community	AMA Status
1 Athens, GA	Crisis
2 Charlottesville, VA	Problem Signs
3 Auburn-Opelika, AL	Problem Signs
4 Bryan-College Station, TX	Crisis
5 Sioux Falls, SD	Problem Signs
6 Huntsville, AL	Problem Signs
7 Nashville, TN	Problem Signs
8 Bellingham, WA	Crisis
9 Raleigh-Durham-Chapel Hill, NC	Crisis
10 Lawrence, KS	Problem Signs
11 Atlanta, GA	Crisis
12 Wilmington, NC	Crisis
13 Olympia, WA.	Crisis
14 Provo-Orem, UT	Problem Signs
15 Richmond-Petersburg, VA	Problem Signs
16 Fayetteville-Springdale-Rogers, AR	Crisis
17 Greenville, NC	Crisis
18 Fort Worth-Arlington, TX	Crisis
19 Knoxville, TN	Problem Signs
20 Jackson, TN	Problem Signs

- **Modern Physician Magazine Rated The Top Communities In The Country To Practice**
- **Ten Of The Top 20 Best Places To Practice Were In "Crisis" – The Rest Showed "Problem Signs"**
- **The AMA Says Doctors Are "Fleeing" The Best Places In The Country To Practice Medicine**

Source: Modern Physician Magazine, October 1st 2003. "Crisis" Data From the American Medical Association.

Medical Malpractice

Are Cap States The Best Place To Practice?



- Modern Physician Magazine Rates The Top Communities In The Country To Practice
- Listed Among The Best Were Nearly Twice As Many Communities In States Without Caps
- Caps Do Not Attract Doctors To A Community

Source: Modern Physician Magazine, October 1st 2003. Criteria for determining best places was from 2002 and before. Any states that passed caps after 2002 were counted as non-cap (TX, FL, MS). Modern Physician Magazine lists the 75 top communities, 26 were entirely within in cap states, 46 were entirely within non-cap states, and 3 communities were in both cap and non-cap states (Fargo-Moorhead ND/MN, Norfolk/ VA Beach VA/NC, and Wilmington/Newark DE/MD).

REAL SOLUTIONS TO THE INSURANCE AND MALPRACTICE PROBLEMS FACING GEORGIA

Pass Insurance Reforms:

- Requiring Disclosure of Insurance Claims Data
- Requiring Prior Approval of Rate Hikes
- Requiring Public Hearings for Rate Hikes Over 10%
- Repealing Insurance Industry's Antitrust Exemption
- Mandating Healthcare Provider Insurance Rate Rollbacks

Pass the "Frivolous Litigation Prevention Act" to penalize frivolous litigants

Pass the "Georgia Hospital Insurance Authority Act" to address the problems of malpractice insurance affordability and availability, especially for rural hospitals that have been price-gouged

Pass Measures requiring public disclosure of "Quality of Care" Data from healthcare facilities so as to educate and empower patients to make informed healthcare decisions

Medical Malpractice Insurance Reform Proposals

1. Requiring disclosure of insurance claims data to enable policymakers and regulators to determine whether malpractice rate increases are justified. For example, requiring malpractice insurers to disclose to the Department of Insurance each malpractice claim filed and paid each year and the amount paid on each claim would answer the question of whether increased litigation has caused malpractice insurance rates to rise. Requiring insurers to disclose their premiums and losses by medical specialty would enable doctors in each specialty to know whether the rates they are being charged are excessive. And requiring malpractice insurers to disclose their premiums and losses by loss experience – i.e., how much they take in and pay out on doctors with zero incidents, with one incident, with two incidents, etc. – would enable doctors with clean records to know whether the rates they are being charged are excessive.

2. Requiring prior approval of medical malpractice insurance rates. In many states, like Georgia, medical malpractice insurers can set their rates without first getting those rates approved by the state insurance department. If malpractice rates could not take effect unless and until they were approved by the Department, malpractice insurers would not be able to raise their rates to the extent they are raising them today. This is borne out by the fact that malpractice insurers have not increased their rates in states that have prior approval to the extent that they have in other states.

3. Requiring an automatic hearing any time an insurer proposes an increase of more than 10%. Public hearings concerning proposed rate hikes is a provision of Proposition 103, the insurance reform package that finally brought stability to the California insurance markets after tort reform failed to do so. This provision has had the effect of limiting proposed rate increases because

insurers want to avoid hearings on rate hikes – especially where there is an active public interest group ready to intervene in such hearings. This provision would grant doctors and hospitals automatic standing to contest proposed rate increases.

4. Repealing the antitrust exemption for the insurance industry. Unlike other businesses, insurers may legally agree among themselves to raise prices or restrict coverage, as well as to engage in other anti-competitive activities that would otherwise violate the antitrust laws. The industry's antitrust exemption thus enables insurers to raise their prices collectively without fear. Prop 103 in California repealed California's antitrust exemption for insurance, and that repeal has helped to both lower insurance rates and smooth out the insurance cycle in California. It could do the same in Georgia.

5. Requiring insurers to roll back their rates to reflect the effect of any tort reforms that might be enacted. Whenever and wherever tort reform is enacted, insurers refuse to reduce their rates. This provision would require them to do so.

The "Frivolous Litigation Prevention Act." This bill, introduced in 2003 as HB 775 and SB 225, would enable a court to severely punish a party and their attorney for filing a frivolous claim or a frivolous defense. It would allow the court to take this action on its own, or pursuant to a motion, at any point in a case. Passage of this bill would address problems that may exist as a result of frivolous lawsuits and frivolous defenses in legitimate lawsuits.

The "Georgia Hospital Insurance Authority Act." This bill, introduced in 2003 as HB 776, would create an entity whose sole purpose would be to purchase liability insurance coverage in bulk for qualifying hospitals. This authority would be financed through the selling of bonds, not tax dollars, and would provide hospitals the benefits of the State's acting as a 'bulk-purchaser.' Because of the particularly difficult time small, rural hospitals have had with price gouging in the past year, this bill should be limited to solving the affordability and availability problems for those hospitals.

Pass a "Quality of Care" Data Reporting Law for Georgia. This bill would require healthcare facilities (hospitals, nursing homes, physicians' practices of a certain size) to publicly report medical error information, best medical practices benchmark compliance data and other data relating to the quality of care their facilities provide to the public so as to educate and empower patients to make informed healthcare decisions.