AFFORDABILITY AND AVAILABILITY OF MEDICAL PROFESSIONAL LIABILITY INSURANCE

July 29, 2026

Maryland
Hospital Association

HOSPITAL LIABILITY RISK IS DIFFERENT IN SCALE, SCOPE, AND STRUCTURE

SCALE

One severe clinical event can result in tens of millions in lifetime-care costs, lost earnings, and other damages.

SCOPE

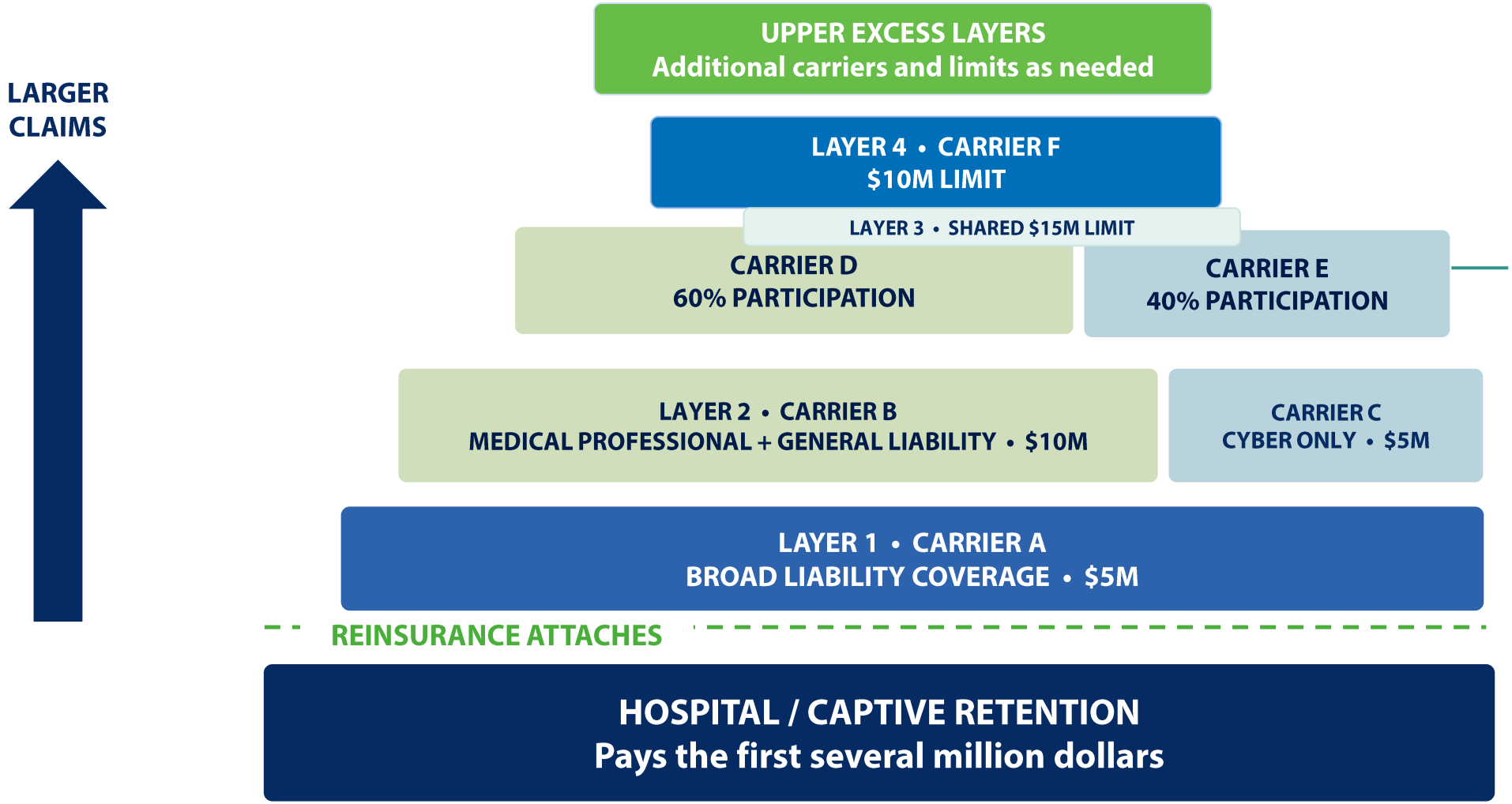
The hospital risk financing program may cover the facility, cyber risks, general tort liability, employees, nurses, employed physicians, and affiliated providers.

STRUCTURE

Hospitals self insure the first layer with their own money. Excess insurance responds only after that retention is exhausted.

Hospitals are health care providers, not insurers.

HOSPITALS BUILD REINSURANCE TOWERS ABOVE A LARGE SELF-INSURED RETENTION



REINSURANCE

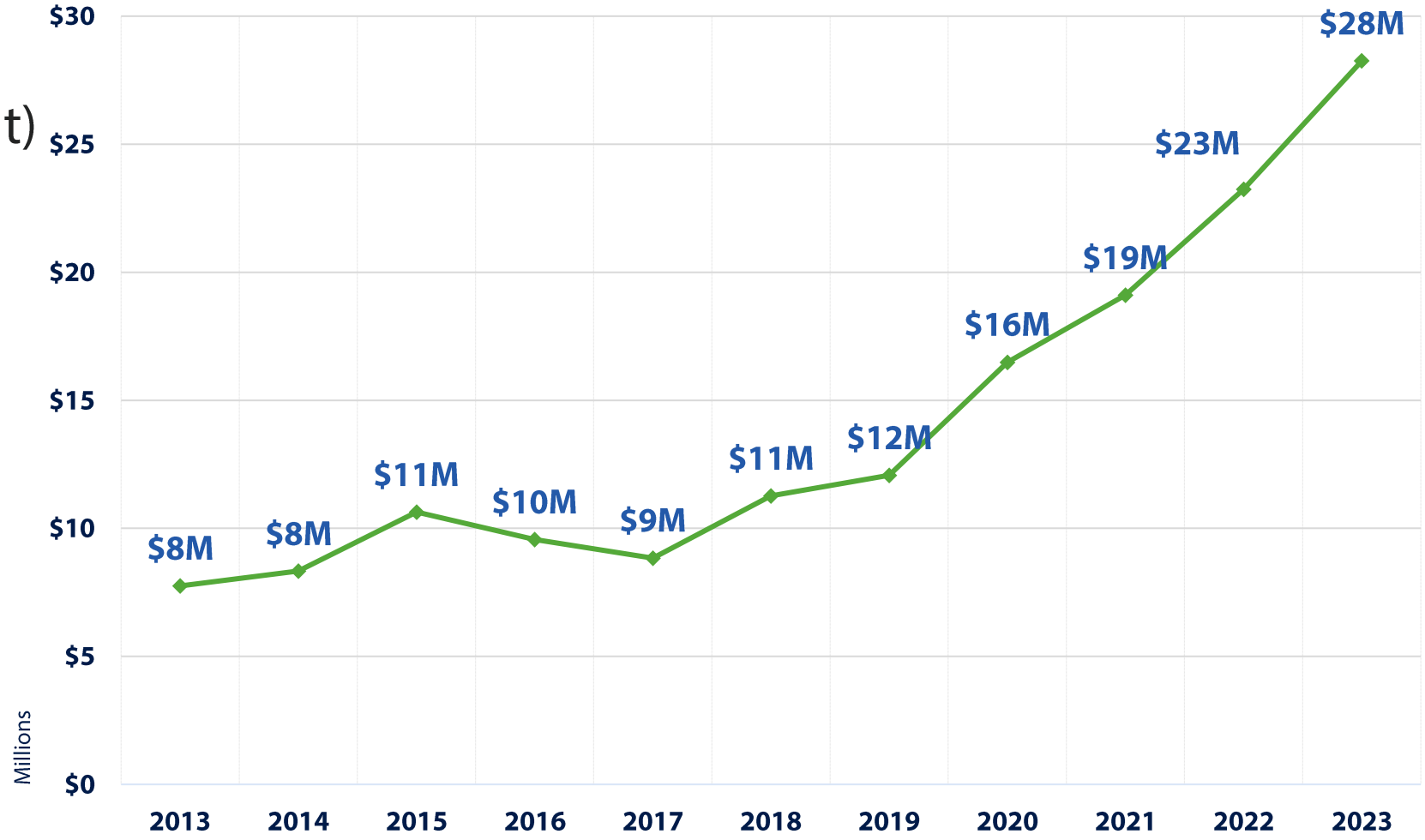
Different insurers may:

- cover different amounts
- share the same layer
- apply different terms, exclusions, and coverage

HOSPITAL ACCESS TO REINSURANCE LIMITED SHARP RISE IN SELF-RETENTION

The average primary retention (attachment point) is **up 265%** from 2013 to 2023

That's **21% growth** (compounded) per year

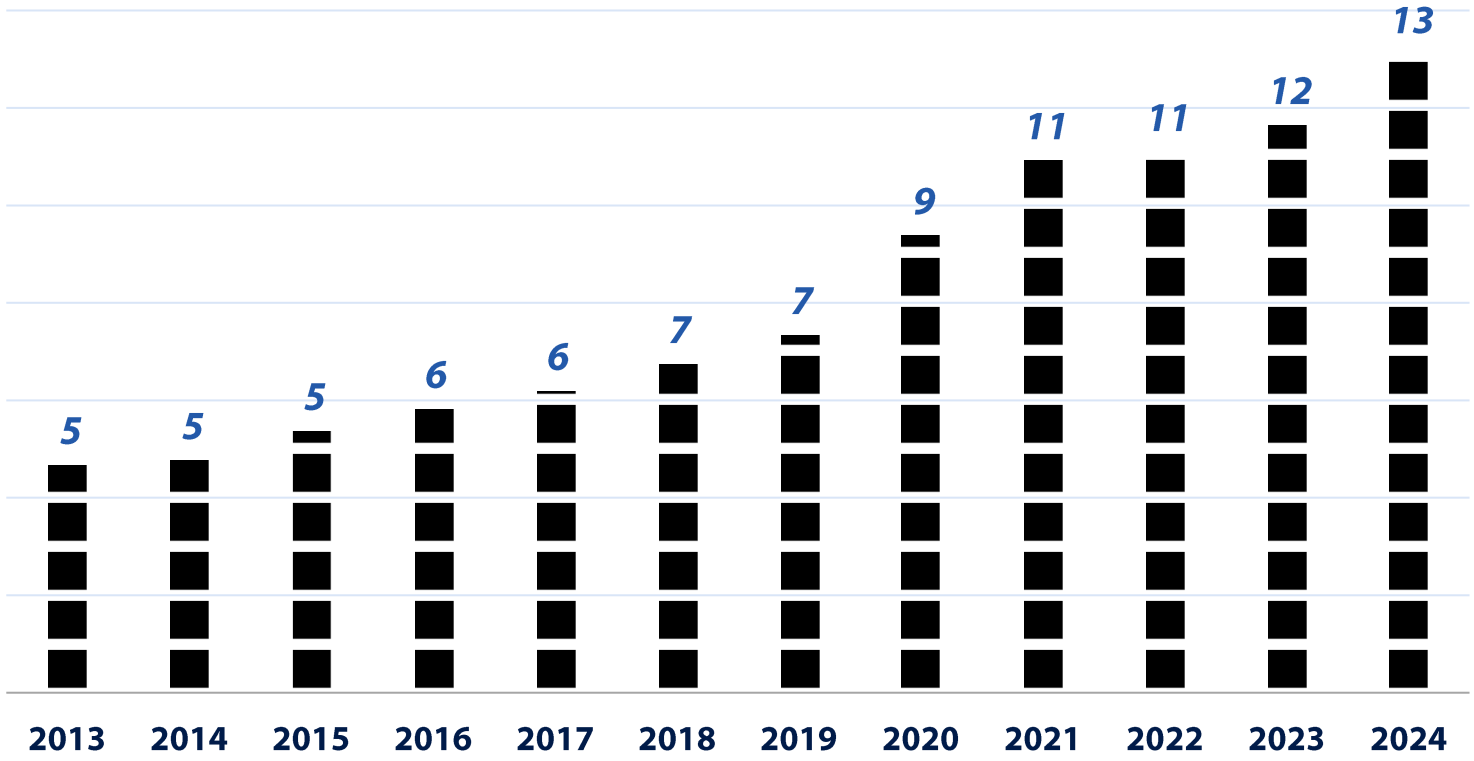


"Attachment Point" refers to the *first dollar* portion of the claim that the hospital (or its self-insured captive) is responsible for paying before excess insurance coverage kicks in to cover the remainder of the claim amount. / Survey Section 1 Question 3. **NOTE:** 2024 Claims data is incomplete within the 2024 calendar year.

SPIKE IN NUMBER OF EXCESS INSURERS REQUIRED FOR ADEQUATE COVERAGE

How many excess insurers did the average (median) hospital/health system require?

2013 to 2024

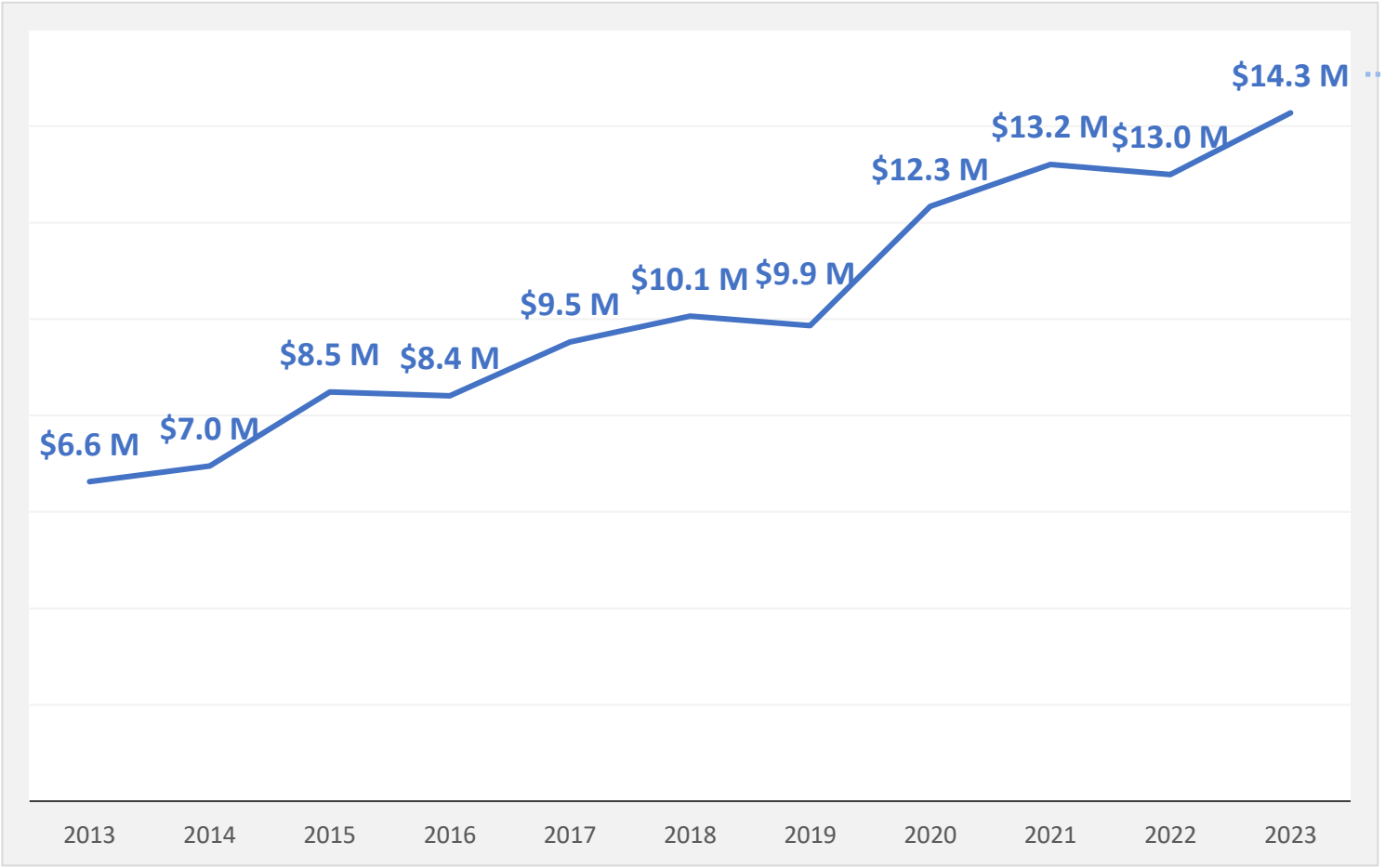


In 2024, the average (median) hospital/health system required 13 excess insurers, **up 160%** from 2013

INSURANCE PREMIUMS MORE THAN DOUBLED

What is the average cost of insurance premiums?

2013 to 2023 | Average of hospitals reporting in MHA's Liability Report



In 2023, MD hospitals averaged $14.3M in premium costs, **more than double** the costs from 2013

NOTE: To accommodate the varying premium renewal dates across systems, and avoid partial reporting, only completed calendar years are charted.

CLAIM FREQUENCY NOT INCREASING

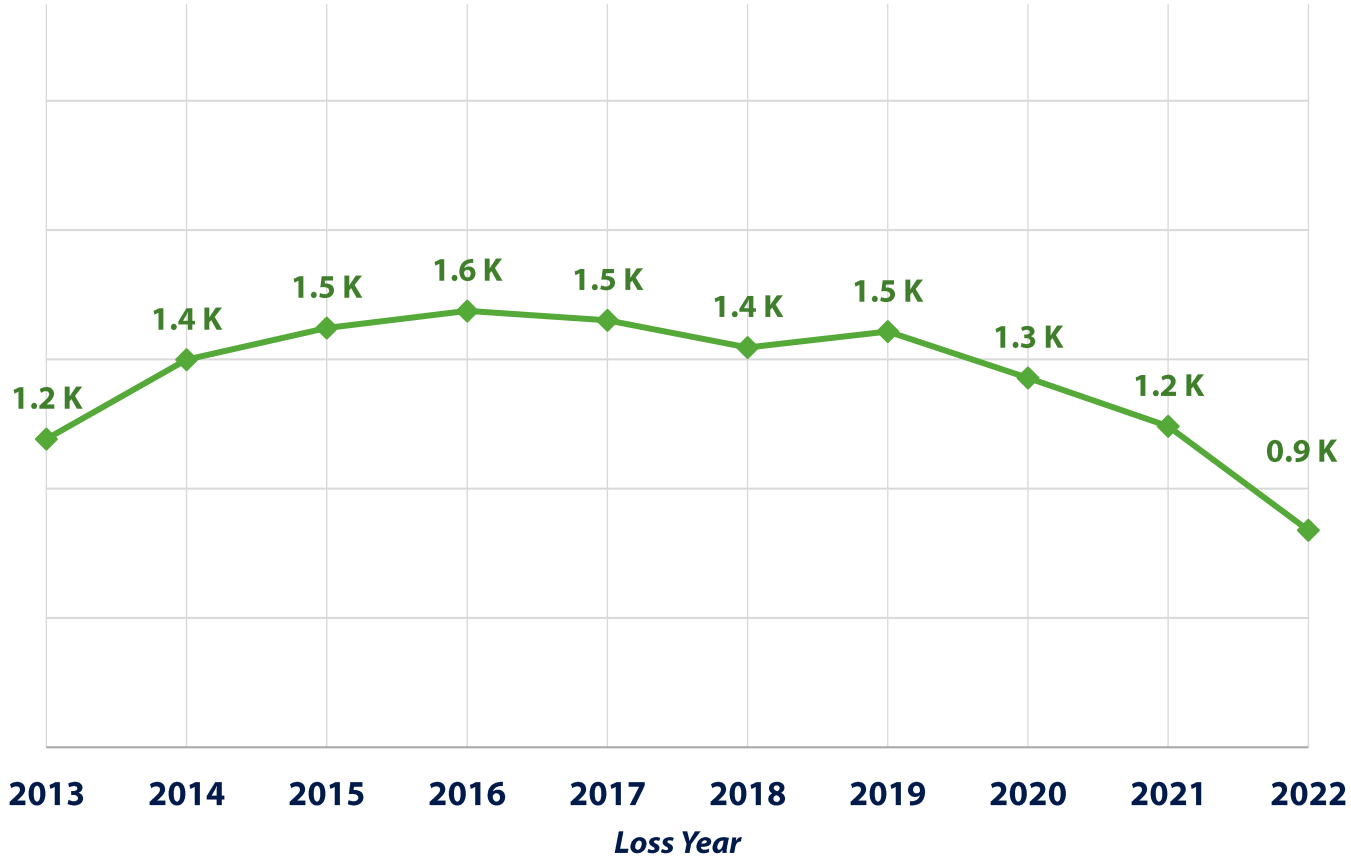
While Maryland hospitals are seeing cost increases for:

- Retention point
- Excess insurance
- Excess insurers
- Insurance premiums

Claim counts are staying relatively flat

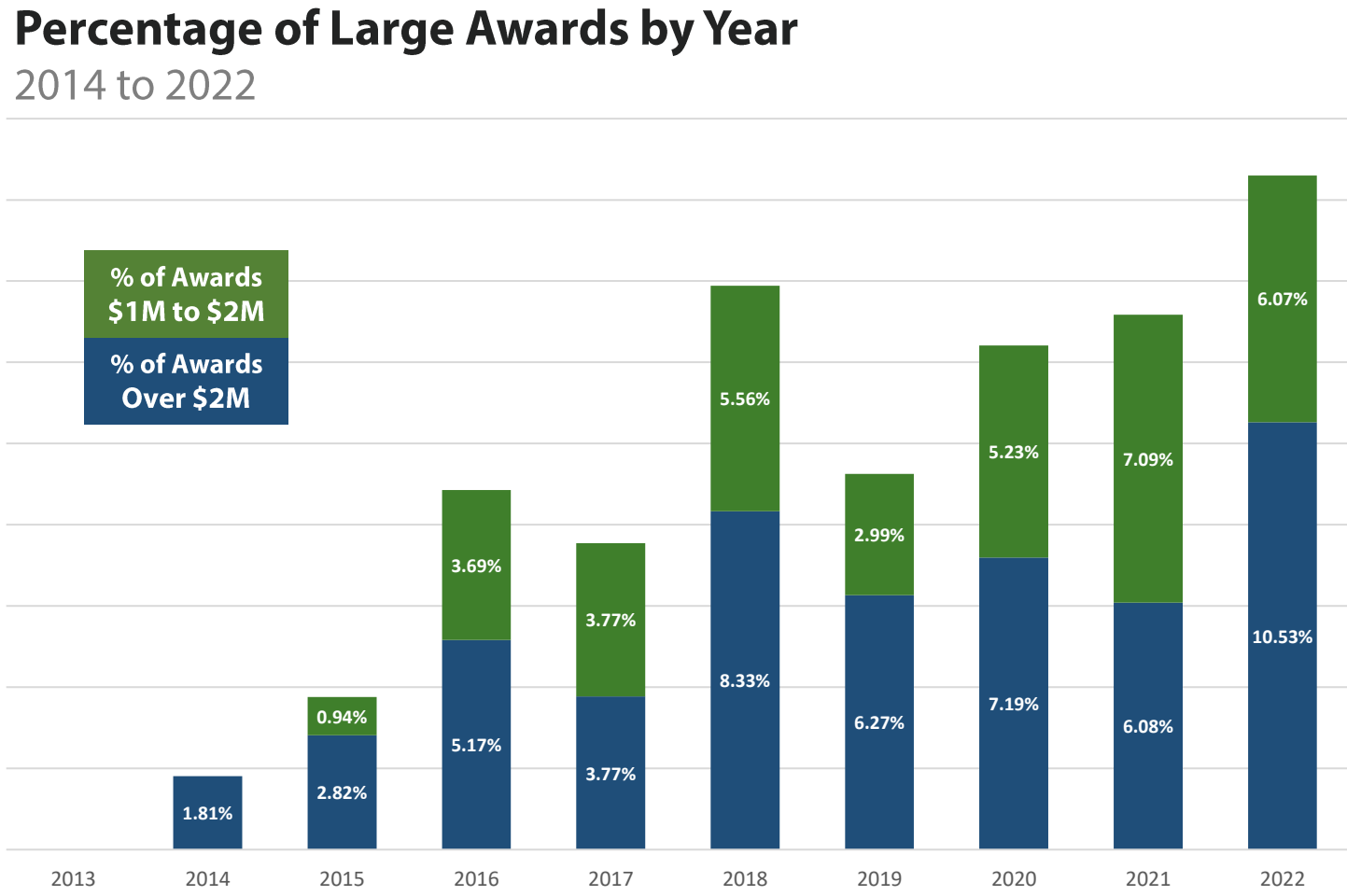
Number of Claims by Loss Year

2014 to 2022



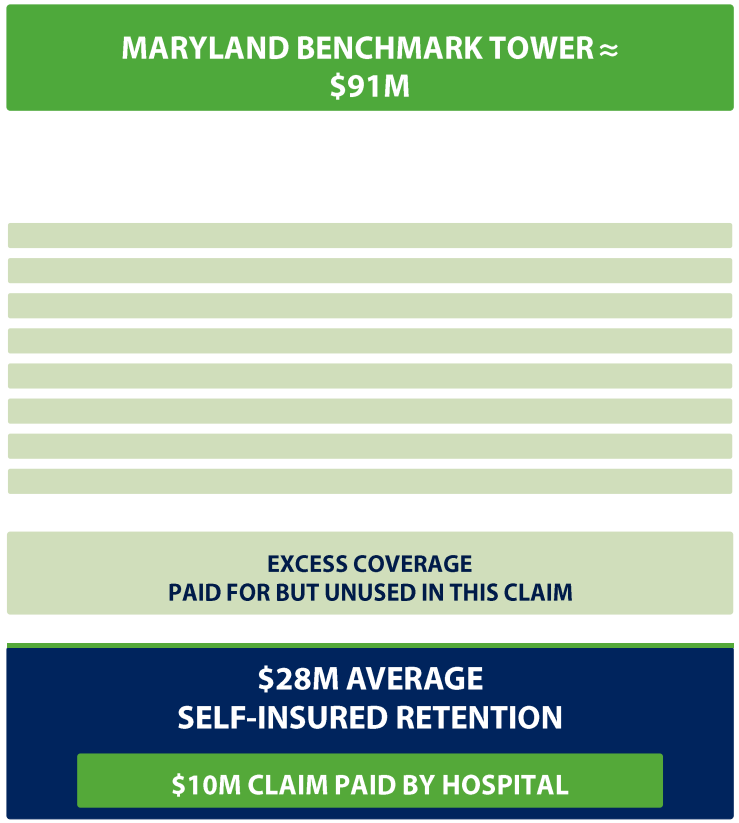
CLAIM SEVERITY INCREASING

Large awards (over $1M) represent 16.6% of claims in 2022, up from 3.9% in 2015



Award amounts include expenses. Data after 2022 incomplete due to insufficient run-out and delays in claimant filings

HOSPITAL MEDICAL PROFESSIONAL LIABILITY—EXAMPLE 1: A $10M CLAIM STAYS WITHIN THE HOSPITAL'S RETENTION

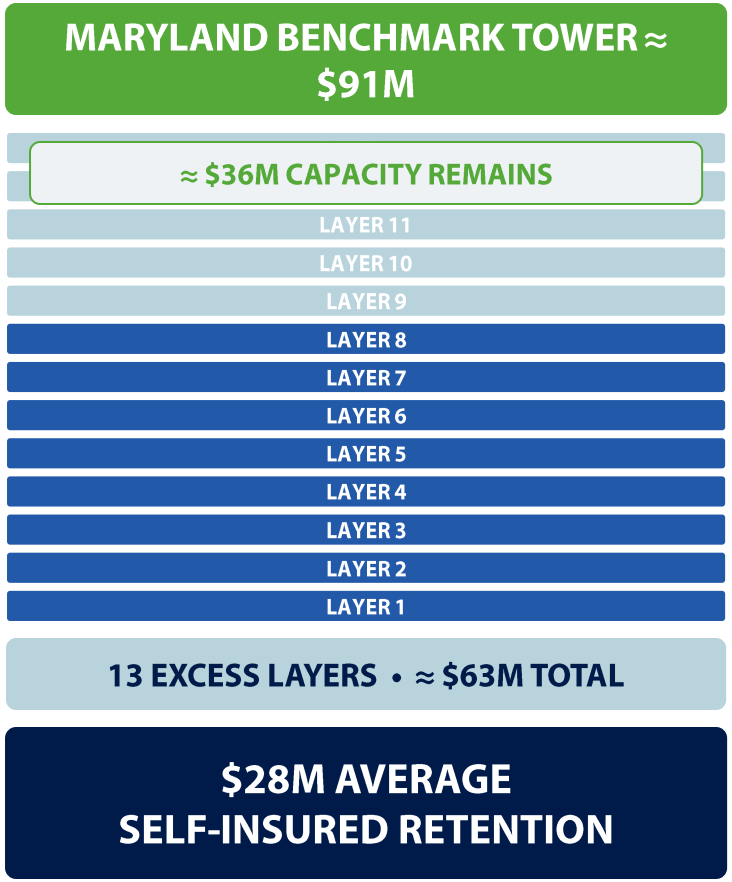


$10 MILLION HOSPITAL LIABILITY CLAIM

$10M	Hospital pays the claim from its own funds
$0	Excess layers are not triggered
$$$	Hospital still pays millions in premiums for excess coverage

MOST CLAIMS DO NOT EXCEED SELF-INSURANCE, SO HOSPITALS OFTEN PAY CLAIMS DIRECTLY WHILE ALSO BUYING PROTECTION FOR RARE CATASTROPHIC LOSSES.

EXAMPLE 2: A COMPLETE TOWER COVERS A $55M MARYLAND MALPRACTICE VERDICT

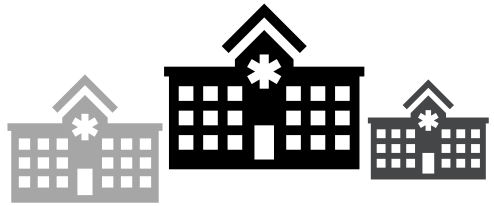


$55 MILLION MARYLAND HOSPITAL VERDICT

$28M	Hospital funds the self-insured retention
$27M	Excess layers fund the balance of the verdict
$0	**Uncovered liability**

THE VERDICT IS FULLY COVERED — AND ≈ $36M OF CAPACITY REMAINS.

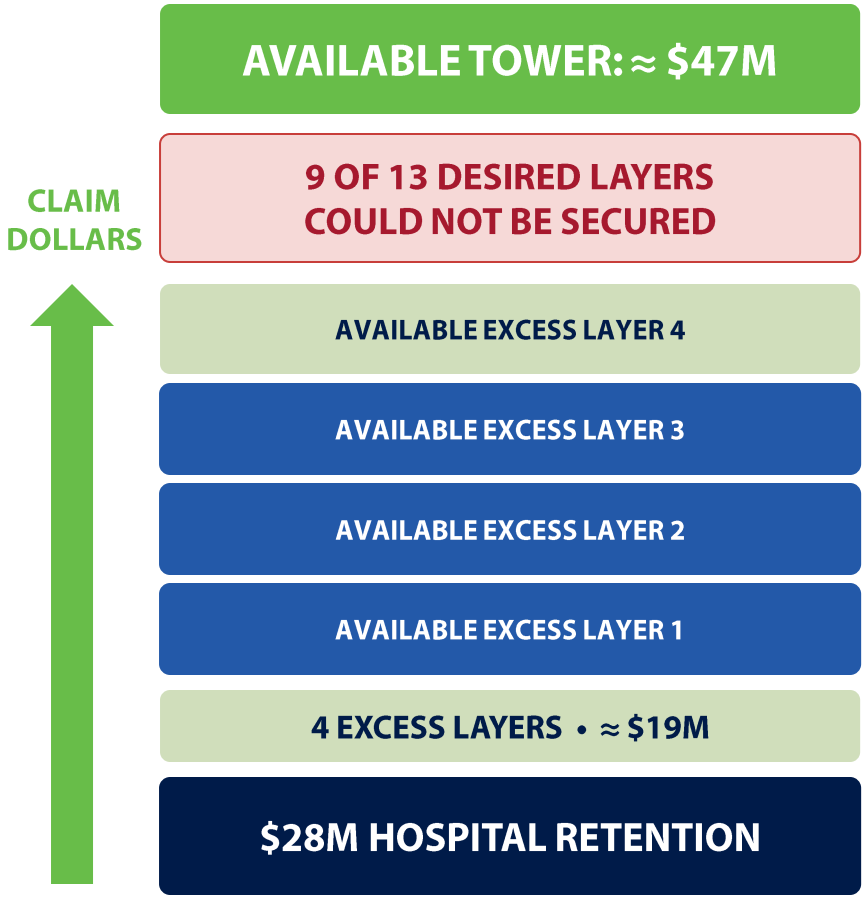
CHALLENGES GREATER AT SMALL FACILITIES



	For all hospitals/ health systems	For small hospitals/ health systems
Median Amount of Excess Insurance Held 2013 to 2022	Up 71%	Up 500%
Median Number of Excess Insurers Required 2013 to 2022	Up 150%	Up 200%
Average Cost of Excess Coverage Premiums 2013 to 2023, 2024	Up 115%	Up 200%

NOTE: Small facilities defined as hospitals or health systems with fewer than 201 beds.

EXAMPLE 3: THE SAME $55M MARYLAND VERDICT EXCEEDS A SHORTER TOWER



SAME $55M MARYLAND JURY VERDICT

$28M	Hospital pays first
≈$19M	All 4 available excess layers are exhausted
≈$8M	**Uncovered after the incomplete tower ends**

THE SAME CLAIM IS NOT FULLY COVERED — THE HOSPITAL MUST FUND THE GAP

EVEN CLAIMS AGAINST CONTRACTED DOCTORS LAND ON THE HOSPITAL

THE HOSPITAL
Owns the ER, keeps the building, holds the reserves

CONTRACTED PHYSICIAN GROUPS
E.G. ER, radiology, anesthesia & hospitalist services — staffed by independent contractors

AGENCY MAKES IT THE HOSPITAL'S LIABILITY
Maryland courts can hold the hospital liable for a contractor's error — as if the doctor were an employee.

So, the contractor's **$1M policy** still becomes the **hospital's multi-million-dollar exposure.**

WHY HOSPITALS ABSORB THE GAP—AND INSURANCE GETS SCARCE

When the doctor's policy is exhausted, the hospital must finance the remaining exposure through its own retention and whatever excess coverage it can obtain.

THE COVERAGE GAP BECOMES A HOSPITAL COST—AND EACH LARGE CLAIM MAKES THE NEXT DOLLAR OF INSURANCE HARDER TO BUY.

EVEN WITH THE CAP, HOSPITAL LIABILITY COVERAGE REMAINS HARD TO SECURE

- Maryland's noneconomic damages cap helps contain claim exposure, but coverage remains unavailable or cost-prohibitive for many hospitals.

Current Market Reality

- **Noneconomic damages are capped**
  The cap limits some exposure, though it rises each year.
- **Coverage is still hard to secure**
  Primary-layer coverage is often unavailable or cost-prohibitive for hospitals.

2026 Policy Pressure

House Judiciary's damages study could recommend a higher cap or no cap

HB 476 / SB 74	**Repeal damages cap**
HB 906 / SB 87	**Lower punitive damages standard**
SB 269 / HB 385	**Shift proving reasonableness of medical bill to providers**
HB 316	**Expand medical-record definition**

- Liability-expanding policies could make coverage more expensive.

MHA RECOMMENDATIONS

1	**SUPPORT AFFORDABLE SELF-INSURANCE OPTIONS FOR HOSPITALS**	Preserve affordable, practical ways for hospitals to fund required retained risk with their own money—including trusts, pooling and other compliant self-insurance mechanisms.
2	**BETTER REPORT THE HOSPITAL INSURANCE MARKET**	Report that primary-layer insurance is largely unavailable to hospitals and capture excess pricing, capacity, attachment points, declinations and coverage restrictions through existing filings and voluntary, aggregated data.
3	**COORDINATE WITH THE HSCRC**	Ensure reasonable, actuarially certified self-insurance funding costs and commercial insurance premiums are recognized within hospital rate structures.

THE PRIORITY: Enable hospitals to sustainably and affordably manage their risk.