Executive Summary

Section I: Lawsuits Are not Responsible for Rising Medical Malpractice Insurance Premiums

- **The number of medical malpractice payouts per 100 doctors has declined 11 percent from 1994 to 2003.** According to the federal Government's National Practitioner Data Bank, in 1994, there were 15,166 malpractice payouts made by physicians in the U.S., which represented 2.46 payouts per 100 doctors. In 2003, there were 15,295 payouts, which represented 2.19 payouts per 100 doctors. Moreover, the total number of payouts has dropped more than 8 percent during the "crisis," from 16,690 in 2001 to 15,295 in 2003.

- **Average physician medical malpractice payouts have increased only 1 percent a year after adjusting for medical services inflation.** According to the National Practitioner Data Bank, in 1994, the average medical malpractice payout in the U.S. was $184,787. That amount climbed to $291,378 by 2003, but when adjusted for medical services inflation the increase was only $18,405, or 1.1 percent a year. Since the bulk of a malpractice payout customarily goes to cover medical expenses, the amount of payouts can be expected to rise along with the costs of medical services. In addition, since a malpractice payout also is intended to provide compensation for lost income over a patient's lifetime, payouts also can be expected to increase along with wages, productivity and life expectancy.

- **Jury verdicts rose only 1.1 percent from 2000 to 2002.** Doctors regularly cite data from Jury Verdict Research, a private research firm, showing that jury awards rose 100 percent from 1997 to 2000, from $503,000 to $1 million. Only time will tell if they cite updated figures showing that the median malpractice verdict rose from $1 million in 2000 and 2001 to $1,010,858 in 200—an increase of only 1.1 percent. This increase did not even come close to keeping pace with medical services inflation.

- **Malpractice insurance costs have risen at three-fifths the rate of medical inflation.** While medical costs increased 125 percent from 1987 to 2002, the total amount spent by all health care providers on medical malpractice insurance has increased by 76 percent over that time.

- **Medical malpractice expenditures comprise less than 1 percent of overall health costs**. In 2002 health care expenditures rose 9.3 percent to $1.553 trillion. Yet expenditures on all malpractice premiums reported to the National Association of Insurance Commissioners (NAIC) that year were only $9.6 billion – making malpractice costs about .62 percent of national health care expenditures.

- **Malpractice insurance costs comprise 3.9 percent of a physician's practice income.** Doctors allocate 13 times more of their practice income for their own salaries than they pay in malpractice premiums. According to the federal government's Medicare program, doctors nationally spend an average of 52.5 percent of their practice incomes on their own

pay, about 31 percent on such overhead expenses as office payroll and rent, and only 3.9 percent on malpractice insurance.

- **Reduced fees—not insurance rates—are the biggest financial burden on doctors.** Doctors across the country have seen their fees slashed in recent years as managed care companies tried to increase profits, and government programs, such as Medicare and Medicaid, tried to cut costs. Medicare reimbursement rates no longer come close to keeping pace with increases in doctors' practice expenses. The American Medical Association (AMA) estimates that since 1991 physician practice costs have risen by 35 percent, but Medicare payments have risen only 10 percent. That means practice costs have risen two-and-a-half times the rate of Medicare payments.

- **Rather than facing "runaway litigation," doctors benefit from a claims gap.** A landmark Harvard Medical Practice Study found that only a small percentage of medical errors result in lawsuits. Twelve years ago, Harvard researchers using a sample of hospitalizations in New York State compared medical records to claims files. They found that only one in 7.6 instances of medical negligence committed in hospitals results in a malpractice claim. Researchers replicating this study made similar findings in Colorado and Utah. From 1996 through 1999, Florida hospitals reported 19,885 incidents but only 3,177 medical malpractice claims. In other words, for every 6 medical errors, only 1 claim is filed.

- **Empirical evidence does not confirm the existence of "defensive medicine."** A search of the scholarly literature on medicine will turn up dozens of studies documenting the incidence of medical errors, but not one peer-reviewed study documenting purely defensive medicine. The Congressional Budget Office (CBO) and The Government Accountability Office have both rejected the defensive medicine theory. The CBO "could find no statistically significant difference in per capita healthcare spending between states with and without malpractice tort limits." Medical provider groups admitted to GAO investigators that "factors besides defensive medicine concerns also explain differing utilization rates of diagnostic and other procedures."

- **Defensive medicine hasn't prevented wrong-patient surgery, medication errors, mammography errors, or hospital infections.** New York hospitals reported 27 instances of invasive procedures performed on the wrong patient between April 1998 and December 2001. An Auburn University study of 36 hospitals and nursing homes in Colorado and Georgia found that on average, 19 percent of medication doses were given in error, with 7 percent judged to be potentially harmful. The *New York Times* reported in June 2002 that studies indicate that some doctors and clinics miss as many as one in three cancers. The *Chicago Tribune* reported on July 21, 2002 that some 75,000 Americans die each year because of infections acquired in hospitals that "were preventable, the result of unsanitary facilities, germ-laden instruments, unwashed hands and other lapses."

- **Doctors aversion to settlements may increase malpractice insurance costs.** Medical malpractice insurers market their product based on aggressive defenses, not on low costs. The Doctors Company, a leading doctor-owned insurer, states on its website: "When litigation is necessary, we dedicate more resources than our competitors to defend your good

name. Our claims representatives and defense attorneys combine their knowledge of regional laws and jury experience to develop *aggressive, successful, defense strategies… We will not consent to settle without your written permission."* (emphasis theirs) The result is that defense attorney fees are higher and verdicts are higher, pushing malpractice premiums higher. The Doctors Company entices customers by boasting that 49 percent of its premiums are spent on defense costs. A study by the West Virginia Insurance Commissioner found that one company spent 88 cents of each premium dollar on defense lawyers. Malpractice insurance defense costs far exceed defense costs in other lines of insurance.

- **Evidence indicates that the negotiation process in medical malpractice cases fails, directly leading to the high verdicts that doctors complain about.** An Ohio State University study compared medical and product liability negotiations. It found that product liability defense attorneys "correctly" predicted jury outcomes (i.e., rejected plaintiff demands that were higher than the jury's eventual verdict) in 12 of the 14 cases studied. By contrast, defense attorneys made the correct settlement decision in only eight of 17 medical malpractice cases in the study. In one case, the defendant rejected a demand of $2 million only to be hit with a judgment for more than $8 million.

- **Few malpractice lawsuits are frivolous.** The high cost of preparing a medical malpractice case discourages frivolous claims – and meritorious claims as well. Medical malpractice cases are very expensive for plaintiffs' attorneys to bring, with out-of-pocket costs for cases settled at or near the time of trial (when most cases are settled) ranging from $15,000 to $25,000. If the case goes to trial, the costs can easily be doubled. These costs do not include the plaintiff's attorney's time, and an attorney pursuing a frivolous case incurs opportunity costs in not pursuing other cases.

Section II: The Insurance Cycle Is the Real Cause of Medical Malpractice Premium Spikes

- **Medical liability premium spike was caused by the insurance cycle and mismanagement, not the legal system.** The property/casualty insurance industry has exhibited cyclical behavior for many years, as far back as the 1920s. These cycles are characterized by periods of rising rates leading to increased profitability. Following a period of solid but not spectacular rates of return, the industry enters a down phase where prices soften, supply of the insurance product becomes plentiful, and, eventually, profitability diminishes, or vanishes completely. In 2001, the current market began to decline or "harden," following an unusually prolonged period of health, called a "soft market," in the property-casualty insurance line in the 1990s.

- **Congressional Budget Office links rising premiums to insurance company investment losses.** In January 2004, CBO noted that the 15 biggest medical malpractice insurers saw their investment returns drop by 1.6 percent from 2000 through 2002. "That figure corresponds to almost half of the 15 percent increase in [medical malpractice premium] rates estimated by the Centers for Medicare and Medicaid Services," the CBO reported.

- **For much of the 1990s, doctors benefited from artificially lower premiums.** According to the International Risk Management Institute (IRMI), "What is happening to the market for medical malpractice insurance in 2001 is a direct result of trends and events present since the mid to late 1990s. Throughout the 1990s, and reaching a peak around 1997 and 1998, insurers were on a quest for market share, that is, they were driven more by the amount of premium they could book rather than the adequacy of premiums to pay losses. In large part this emphasis on market share was driven by a desire to accumulate large amounts of capital with which to turn into investment income." IRMI also noted: "Clearly a business cannot continue operating in that fashion indefinitely."

- **Financial analysts recognize the true cause of premium spikes.** Weiss Ratings reports that, "Tort reform has failed to address the problem of surging medical malpractice premiums, despite the fact that insurers have benefited from a slowdown in the growth of claims… The escalating medical malpractice crisis will not be resolved until the industry and regulators address the other, apparently more powerful, factors driving premiums higher." According to Weiss, six factors driving increases in medical malpractice rates are medical cost inflation, the cyclical nature of the insurance market, the need to shore up reserves for policies in force, a decline in investment income, financial safety, and the supply and demand for coverage.

- **Insurer mismanagement compounded the problems.** As the *Wall Street Journal* found in 2002, "[A] price war that began in the early 1990s led insurers to sell malpractice coverage to obstetrician-gynecologists at rates that proved inadequate to cover claims. Some of these carriers had rushed into malpractice coverage because an accounting practice widely used in the industry made the area seem more profitable in the early 1990s than it really was. A decade of short-sighted price slashing led to industry losses of nearly $3 billion last year."

- **The American Medical Association acknowledges that spikes in malpractice premiums are caused by insurance cycles.** A report by the AMA's Board of Trustees to its House of Delegates, stated, "The insurance underwriting cycle is now at a point where insurers have both pricing power and a need to increase revenues through premiums as returns on investments are no longer able to subsidize underwriting loses [sic] and as insurers have suffered large claims losses in other areas."

- **The end of the "hard" insurance market is in sight.** Insurers returned to profitability in 2002, indicating that the hard market bottomed out in 2001. According to the National Association of Insurance Commissioners, property/casualty insurers posted a net loss in 2001 but began a rebound in 2002. U.S. property/casualty insurers' profits surged to $29.9 billion in 2003, according to the Insurance Services Office Inc. and the Property Casualty Insurers Association of America. According to the Insurance Information Institute, return on equity in 2004 is likely to soar above double digits for the first time since 1997 because underwriting performance is expected to continue to improve and the investment environment should allow for the realization of significant capital gains as well as higher investment yields on the industry's bond portfolio.

Section III: The Real Medical Malpractice Crisis Is Inadequate Patient Safety

- **Patients need protection from an epidemic of medical errors and unsafe practices in medicine.** Between 44,000 and 98,000 Americans die in hospitals each year due to *preventable* medical errors, according to the Institute of Medicine. By comparison the annual death toll from automobile accidents is 43,000, 42,000 die from breast cancer and 15,000 die from AIDS.

- **Medical journals, state reporting systems and news accounts document continuing, widespread inattention to patient safety.** According to a study published in the *Annals of Internal Medicine*, New York hospitals reported 27 instances of invasive procedures performed on the wrong patient between April 1998 and December 2001. And a 2003 study published in the *New England Journal of Medicine* reported that operating room teams around the country leave sponges, clamps and other tools inside about 1,500 patients every year. The study found that surgical teams failed to count equipment before and after the operation, as required by standard practice, in one-third of cases where something was left behind.

- **The resources devoted to preventing medical errors are disproportionate to their toll in lives.** Deaths attributable to preventable medical errors in hospitals each year exceed those caused by breast cancer and AIDS. Yet while the federal government spent $655 million on breast cancer prevention in 2003 and $3.5 billion on AIDS prevention in 2001, only about $130 million was committed in 2002, for the first time, for improving patient safety.

- **Physicians' cavalier attitudes toward medical errors are out of step with public opinion.** In 2002, the *New England Journal of Medicine* released a survey of physicians and the public on the issue of medical errors. On each of these issues, doctors were in significant disagreement with the public and the experts. The public understands the need for better nurse staffing. The public understands the role of fatigue in causing injuries to patients. The public wants hospitals to develop patient safety systems. The public wants computerized prescriptions and medical records. The public wants mandatory reporting of medical errors. The public wants stronger disciplining of doctors.

- **Patients and consumers suffer the real costs of medical malpractice.** The cost resulting from preventable medical errors in hospitals to patients, families and communities is estimated at $17 billion to $29 billion each year. But the cost of medical malpractice insurance to health care providers is only $9.6 billion a year—about half the minimum costs to society of preventable medical errors.

- **5.4 percent of doctors are responsible for 56.2 percent of medical malpractice payouts.** This is according to National Practitioner Data Bank data from September 1990 through 2003. Each of these doctors has made at least two payouts. Just 2 percent of doctors, each of whom has made three or more malpractice payouts, were responsible for 31.1 percent of all payouts. Only 0.9 percent of doctors, each of whom has made four or more malpractice

payouts, were responsible for 18.8 percent of all payouts. Eighty-three percent of doctors have never made a medical malpractice payout since the NPDB was created in 1990.

- **Doctors with repeated malpractice payouts suffer few consequences.** Only 8 percent of doctors who made two or more malpractice payouts were disciplined by their state medical board. 11.1 percent of doctors who made three or more malpractice payouts were disciplined by their state board. Only 14.4 percent of doctors who made four or more malpractice payouts were disciplined by their state board. Even of those doctors who made 10 or more malpractice payouts only 32.2 percent were disciplined by their state board.

- **Anesthesiologists' experience shows patient safety efforts do more than caps to reduce lawsuits and insurance premiums.** In 1985 the American Society of Anesthesiologists (ASA) began gathering claims files from 35 different insurers. The outcome of this Manhattan Project-like commitment was the issuance of standards and procedures to avoid injuries that resulted in savings beyond the wildest dreams of any "tort reformer:" The number and severity of claims dropped dramatically. In 1972, anesthesiologists were the target of 7.9 percent of all medical malpractice claims, double their proportion among physicians. But from 1985 to 2001, they were targets of only 3.8 percent of claims. In the 1970s, 64 percent of anesthesiology claims involved permanent disability or death; by the 1990s, only 41 percent did. The increased patient safety measures paid off in savings to doctors. Remarkably, the average anesthesiologist's liability premium remained unchanged from 1985 to 2002 at about $18,000 (and, if adjusted for inflation, it would be a dramatic decline).

Section IV: Malpractice Insurance Crisis Is not Threatening Access to Patient Care

- **Congressional watchdog agency finds claims of malpractice insurance "crisis" unsubstantiated.** The U.S. Government Accountability Office, formerly the General Accountability Office, essentially found that the AMA and allied groups manufactured a "crisis." The GAO compared conditions in five AMA-designated "crisis states," and found that the AMA's claims that medical services were unavailable in particular areas because of malpractice costs were not reliable; and claims that the overall number of doctors in the "crisis" states had declined were based on questionable surveys.

- **A case study in deception: The phony "doctor exodus" in Pennsylvania.** According to an independent study by the *Allentown Morning Call* newspaper, "Pennsylvania doctors are not leaving in droves because of rising malpractice premiums." "New state government statistics, the first to shed definitive light on a factually murky crisis that has consumed state officials and panicked consumers, show little or no dip in the number of doctors…And a separate set of previously undisclosed figures—from the Pennsylvania Medical Society itself—indicate there probably are more physicians in Pennsylvania than ever."

- **A spot-check of anecdotes cited by the AMA as evidence that there is reduced access to care in Pennsylvania found many of the stories to be false.** In February

2004, Public Citizen performed a spot-check of anecdotes contained in the appendix to American Medical Association president-elect John C. Nelson's statement to a U.S. House subcommittee. Public Citizen's findings indicate that anecdotes of a doctor exodus are often inaccurate. For instance, the AMA claimed that Dr. Carol Ludolph, "a neurosurgeon in Philadelphia, said that $170,000 in liability insurance premiums forced her to stop performing brain surgeries" in 2002. However, calls to her office confirmed that Dr. Ludolph is still taking new patients and still performing brain surgeries.

- **Stories of reduced access to trauma care are exaggerated.** A study published in 2003 in the *Journal of the American Medical Association* identified 10 states with the highest concentration of trauma centers. But five of those were states where the AMA claimed patients were threatened with lack of access to health care due to rising malpractice insurance premiums – i.e., that there were not enough doctors. Meanwhile, four of the six states that the AMA said are "currently OK" were found to have fewer than the recommended number of trauma centers, despite harsh caps on damages to victims of medical malpractice.

- **Shortage of rural doctors is a chronic problem, unrelated to malpractice.** For 25 - 30 years many rural communities have been under-served medically according to experts. The Council on Graduate Medical Education (COGME) reports that geographic mal-distribution of health care providers and services are one of the most persistent characteristics of the American health care system. Physicians tend to practice in affluent urban and suburban areas. Even as an oversupply of some physician specialties is apparent in many urban health care service areas across the country, many inner-city and rural communities still struggle to attract an adequate number of health professionals to provide high-quality care to local people.

- **Why doctors practice where they do: Quality of life, not caps on damages.** Liability laws do not correlate with where doctors' locate their practice. While four of the states with the fewest per capita number of doctors in 2004 had enacted caps on non-economic damages, only three of the states with the most number of doctors per capita had enacted them. Similarly, while three of the states with the fewest number of doctors had enacted caps on punitive damages, only one of the states with the most number of doctors had capped punitive damages. Doctors choose to reside in states with a higher quality of life, not because of state liability laws. Like anyone else, doctors want to live in places where they can earn high incomes, enjoy cultural and leisure activities, and send their children to good schools. It is not surprising that doctors migrate to states on lists of "Best Places to Live."

Section V: Caps on Damages Are Unjust and Offer No Solution to Rising Premiums Caused by the Insurance Cycle

- **Caps on damages are unjust**. "Non-economic" damages are not as easy to quantify as lost wages or medical bills, but they compensate real injuries. They are awarded for the pain and suffering that accompany any loss of normal functions (e.g. blindness, paralysis, loss of sexual function, lost bowel and bladder control, loss of limb) and inability to engage in daily activities or to pursue hobbies, such as hunting and fishing. This category also encompasses damages for disfigurement and loss of fertility.

- **Three academic studies demonstrate severely handicapped and female patients are hurt the most by caps.** These 2004 studies from physicians at the Harvard Medical School, social scientists at the RAND Institute for Civil Justice and a law professor at the University of Buffalo analyzed the impact of California's twenty-nine year old $250,000 limit on non-economic damages. Each study reached the same conclusion – caps are a particularly harsh method of reducing malpractice awards.

- **Average reductions for grave injuries were seven times larger than for those with minor injuries, according to the study by the Harvard Medical School.** Verdicts for injuries such as deafness, numbness, disfigurement, chronic pain and the like, which do not always result in wage loss or high medical expenses, were virtually wiped out by the cap. The authors concluded that caps are a clumsy and inequitable solution to the perceived problem of unjust jury awards. .

- **Plaintiffs with the most severe injuries felt the impact of MICRA the most often, according to the study by the RAND Institute.** Patients with the most serious injuries, such as brain damage, a variety of catastrophic injuries, and paralysis, had their awards capped most frequently, and when they do, they suffered median reductions of more than a million dollars. Cases with the greatest percentage losses in total awards are those with small economic losses but great damage to the plaintiff's quality of life. An example is the case of a 42-year old woman who underwent an unnecessary mastectomy because of a mistaken diagnosis of cancer; the jury verdict was $78,000 for economic losses and $1.5 million for the non-economic losses to her quality of life. Under the MICRA cap, the judge reduce her total award to $338,000, 78 percent less than the jury had decided was fair compensation.

- **California women sustain greater proportional losses from the cap than men, according to the University of Buffalo study.** Verdicts for women were reduced an average of 48 percent as compared to only 40 percent for men. California caps have a particularly harsh impact on women who are victims of gynecological malpractice. In the gynecological cases studied the average reduction was 64 percent. Elderly women and parents of children who died as the result of malpractice were also hard hit by the one size fits all California cap, according to the author.

- **California's lower malpractice insurance premiums are the result of insurance reform not the damage cap.** In 1975, California passed the Medical Injury Compensation Reform Act (MICRA), the centerpiece of which is a $250,000 cap on non-economic damages (with no inflation adjustments). But California premiums continued to rise after enactment of the MICRA cap. In 1976, the first year of MICRA, the total premiums earned by California insurers was $228.5 million but by 1988, after thirteen years of MICRA, premiums had skyrocketed to $663.2 million, a jump of 190 percent. Malpractice premiums only began to decrease in 1988 after passage of Prop 103. Prop 103 was the nation's most stringent reform of the insurance industry's rates and practices. Within three years of California's passage of Prop 103, medical malpractice premiums dropped 20 percent, and since 1988 total premiums earned have decreased about 2 percent, dropping from $663.2 million in 1988 to $647.2 million in 2001.

- **Caps on Malpractice Awards Do Not Improve Access to Primary Care.** Government data shows that 53 percent of the 15 states with the worst access to primary care impose medical malpractice damage caps. Among the 15 states with the highest percentages of population lacking primary medical care, eight impose malpractice caps, according to the Health Professional Shortage Area database maintained by the U.S. Department of Health and Human Services. In fact, two of the four states with the greatest underserved populations have malpractice caps. Meanwhile, among the 15 states with the smallest percentages of population lacking primary care, nine do *not* have malpractice caps, according to the Health Professional Shortage Area database. The alleged "crisis" states of New Jersey, Pennsylvania, Connecticut, Illinois and Ohio are ranked 2nd, 8th, 9th, 13th and 14th best in the country for their population's access to primary care.

- **Medical providers can reduce the number of medical malpractice claims brought through conflict management systems and honesty policies.** Most victims of medical malpractice want the same thing – and it isn't money. Patients and families with medical concerns usually want a combination of three things: an acknowledgement of their suffering with an apology if appropriate, a straightforward explanation of what happened, and assurances that the incident will not be repeated. Steve Kraman, chief of staff at the Veterans Affairs Medical Center in Lexington, Kentucky puts it this way: "If you treat people the way that they want to be treated, they don't want to take you to court." Hospitals and insurers that have honesty policies or conflict management systems have seen a reduction both in the number of malpractice claims filed and in payouts, *without legislation and without taking away patients' rights.* The Veterans Affairs Medical Center in Lexington has a policy of telling patients when mistakes are made and automatically compensating victims. Despite readily acknowledging fault, the center ranks in the lowest 25 percent of all VA medical centers in malpractice expenses.