Bush's Medical Malpractice Disinformation Campaign: A Rebuttal to the HHS Report on Medical Liability

Congress Watch
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This report was written by Public Citizen's Congress Watch Legislative Counsel Jackson Williams, based on research provided by Civil Justice Fellow Gretchen Denk, Legislative Assistant Rebecca Romo, Special Counsel Barry Boughton, and Senior Researcher Andrew Benore. Congress Watch Director Frank Clemente provided significant editorial direction.

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Public Citizen's Congress Watch
215 Pennsylvania Ave S.E.
Washington, D.C. 20003
P: 202-546-4996
F: 202-547-7392
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Introduction

The medical community continues to tout a report, Confronting the New Health Care Crisis: Improving Health Care Quality and Lowering Costs By Fixing Our Medical Liability System, issued by the Department of Health and Human Services last summer as making an overwhelming case for medical liability "reform."[1] In truth, a cursory examination of the report finds it to be a classic "clip job"—a collection of anecdotes, reports, and propaganda provided by lobbyists and stamped with the government's official imprimatur. The report cites such sources as Fox News Channel, Congressman Chip Pickering, and the Physician Insurers Association of America, the trade group leading the lobbying campaign. *It contains no new research nor any data generated by government health care experts or economists.*

A more intensive examination of the report shows that most of the "facts" it provides are incorrect, incomplete, or misleading; and that its conclusions are contradicted by those of other government agencies.

Divided Government: How Agency Experts' Views on Medical Malpractice Issues Differ from Those of Political Appointees in HHS

Fortunately, the government doesn't speak with one voice. Our survey of information issued by eight other official sources paints a more accurate picture, directly refuting many of the claims in the HHS report. This is what other government agencies with expertise on health care, data collection and economics say about medical errors and lawsuits to compensate them:

National Practitioner Data Bank (NPDB): Actual payments to malpractice victims are only a fraction of what juries award. Inexplicably, the HHS report cites highly skewed jury verdict data from a private source, Jury Verdict Research (JVR), overlooking the far more comprehensive and reliable data collected within HHS itself. That NPDB data shows that the median payment to a victim in 2000 was just $125,000, not the $1 million median verdict reported by JVR; and that verdicts, which occur in only four percent of medical malpractice cases, are reduced to a median of $235,000 upon final judgment.

National Practitioner Data Bank: A small number of "repeat-offender" doctors are responsible for most malpractice, and licensing boards are doing nothing about it. Federal law requires all medical malpractice judgments and settlements, as well as disciplinary actions against doctors, to be reported to the NPDB. NPDB data shows that just 5 percent of U.S. doctors are responsible for 54 percent of all malpractice, and that only a small percentage of even the worst doctors ever have their licenses revoked.

Congressional Budget Office (CBO): Malpractice expenditures constitute a tiny fraction of overall health care costs, and changes to the legal system would make a negligible difference. When asked to score the "savings" from the president's malpractice proposal (embodied in H.R. 4600 which passed the U.S. House in 2002), the non-partisan CBO said the legislation that embodied President Bush's plan would merely shift costs, and that "even a very large reduction in malpractice costs would have a relatively small effect on total health plan premiums."

Congressional Budget Office: "Defensive medicine" imposes no quantifiable costs on the health care system. CBO said "there is little empirical evidence on the effect of medical malpractice tort controls on spending for defensive medicine and, more generally, on overall health care spending."

U.S. Census Bureau Data: Awards to plaintiffs correlate with income and urbanization, and don't result from arbitrary jury "jackpots." Public Citizen entered Census statistics into a regression with NPDB statistics on malpractice awards. The result: median state family income and population density are responsible for most variation in awards.

Medicare Payment Advisory Commission (MedPAC): Malpractice insurance costs amount to only 3.2 percent of the average physician's revenues. Independent MedPAC economists also reported last December that premiums rose in the aggregate in 2002 by just 4.4 percent.

Institute of Medicine (IOM): Preventable medical errors result in 44,000 to 98,000 deaths annually. As an arm of the congressionally-chartered National Academy of Sciences, IOM is the governments' official adviser on health care issues. IOM identified medical errors, not medical liability lawsuits, as the nation's true malpractice problem. The HHS report cites only the IOM's proposal for voluntary reporting of "near miss" medical errors, whose non-implementation it blames on lawyers. The report does not mention IOM's findings about the death toll and the $17-29 billion in annual costs attributable to medical errors; nor its proposals for mandatory reporting and recertification of providers.

Centers for Disease Control (CDC): An epidemic of hospital-acquired infections, many preventable, is killing tens of thousands every year. CDC estimates that some 2 million hospital patients acquire infections that result in 90,000 deaths each year. One CDC expert says that "many hospital personnel fail to follow basic infection control, such as hand washing between patient contacts."

Council of Economic Advisors: The tort system promotes patient safety. Although the Council also consists of the president's political appointees, its economists declined to endorse a "junk-science" approach to medical malpractice. The Council says that the ability of a patient to pursue a lawsuit "provides an additional incentive for the physician to follow good medical practice…recognition of the expected costs from the liability system causes the provider to undertake the extra effort or care that matches the customer's desire to avoid the risk of harm."

The HHS Report: Public Citizen's Analysis of a Few Nuggets of Wisdom

HHS political appointees refused to allow facts, objectivity, or even common sense to get in the way of producing the report that the medical and insurance lobbies demanded. Here are just a few nuggets of wisdom from the report:

Read my lips: The costs of the "runaway litigation system" are leading to "higher taxes." (p.7)

Reality check: "Runaway litigation" hasn't prevented the Administration from proposing another tax cut.

Twelve angry men: Giving juries "a blank check to award huge damages" is "not a democratic process." (p.9)

Reality check: One could argue that the jury system is *too* democratic, but how could it be *un*democratic?

Health care is hazardous to your health: The tort system is hazardous to patients' health because it causes physicians to provide *too much* medical care, and "every test and every treatment poses a risk to the patient." (p.5)

Reality check: Suffice it to say that only the most extreme right-wing ideologue could say this with a straight face.

Fuzzy math: Without citation, the report says that the federal government spends "$3.91 billion in liability insurance paid to Medicare, Medicaid, Veteran's Affairs, and other federal programs (sic)." (p.7, EN 30)

Reality Check: Only $6.4 billion was spent on *all* medical malpractice liability premiums in 2000, according to the National Association of Insurance Commissioners. The $3.91 billion figure implies that 61 percent of health care expenditures are paid by the federal government, when in fact the percentage is just 32 percent.[2]

We report, you decide: Fox News Channel is cited for the proposition that "between 1999 and 2000, median malpractice awards increased nearly 43 percent." (p.9)

Reality check: If political staffers turned off the television and read agency (such as NPDB) reports, they would find that the median award rose by 15 percent during that time, the same rate of increase as health insurance premiums.

Maybe Goldwater sawed them away: The report compares average premium increases in ten states with damage caps to increases in ten states without damage caps.

Reality check: What about the other 30 states in the U.S.? Medical Liability Monitor reported on their rate changes too, but HHS omits them from its "comparison."

The following sections of this report refute each of the seven points made in the HHS report.

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[1] U.S. Department of Health and Human Services, Office of the Assistant Secretary for Planning and Evaluation, Confronting the New Health Care Crisis: Improving Health Care Quality and Lowering Costs By Fixing Our Medical Liability System, July 24, 2002.

[2] Heffler et al, "Health Spending Growth Up in 1999," Health Affairs, March 2001.

The Bush Administration Says: "Access to Care is Threatened"

"There are a number of obstacles that limit access to affordable health care in this country, including lack of affordable insurance and an outdated Medicare program. We now face another--the litigation crisis that has made insurance premiums unaffordable or even unavailable for many doctors, through no fault of their own. This is making it more difficult for many Americans to find care, and threatening access for many more. Dr. Cheryl Edwards, 41, closed her decade-old obstetrics and gynecology practice in Las Vegas because her insurance premium jumped from $37,000 to $150,000 a year. She moved her practice to West Los Angeles, leaving 30 pregnant women to find new doctors."

The Facts: Malpractice insurance costs are a miniscule part of a doctor's expenses and don't affect decisions about where to practice medicine.

- **There is a greater likelihood of doctors withdrawing from practice due to increases in their office rents or payroll costs than due to increases in malpractice insurance costs.** While there is a temporary spike in medical malpractice insurance rates due to insurance industry economics, it is necessary to look at the larger and longer-term picture. Specifically, while physicians spend about 3.2 percent of their gross income on medical malpractice costs, they spend 17 percent on payroll costs and 5.8 percent on office rent.[1] According to the Medicare Payment Advisory Commission (MedPAC), the average increase in medical malpractice insurance rates last year was 4.4 percent.[2] A doctor who stops practicing because of a malpractice insurance increase would be just as likely to retire due to increased health insurance costs for office staff, or because of increased rent for office space. If increased costs to doctors justify legislative action, they could also justify repeal of wages and hours laws or enactment of rent control laws.

- **Liability laws have no effect on a doctor's decision where to practice.** Even though damage awards are higher in more affluent states, those states still have more doctors. The District of Columbia has the highest average damage award and the most doctors. Idaho, with the fewest doctors, has the third lowest median damage award.[3] While five of the states with the lowest per capita number of doctors have enacted caps on non-economic damages, only three of the states with the highest number of doctors per capita have enacted them. According to the U.S. Chamber of Commerce, Iowa, Utah, and South Dakota rank 5th, 8th and 9th for "reasonable litigation environment,"[4] yet those states rank in the bottom ten in number of doctors. Only one state in the Chamber's legal climate top ten, Connecticut, also ranks in the top ten for doctors. California, whose damage caps supposedly drew Dr. Edwards from Las Vegas, did not add one additional doctor per 100,000 residents between 1990 and 1999, but the number of doctors per 100,000 residents increased in Nevada from 136 to 162 during that period.

- **Two factors explain almost all the variation in the number of doctors in a state: income level and urbanization.**[5] 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. Seven of the top ten states for doctors also rank in the top ten states in percentage of households earning $200,000 or more.[6] Doctors want to live in areas with lots of affluent people—such areas are more likely to have the leafy suburbs, premium housing, clubs, and other amenities that doctors want. For every $1,000 increase in a state's median income for a four-person family, a state will have 2.3 more doctors per 100,000 residents. Doctors migrate to states on lists of "Best Places to Live": Forty of the top 100 cities with "strong arts, cultural programs, and higher education" were in the ten states with the highest per capita number of doctors, while there were none in the ten states with the lowest per capita number of doctors.[7] Polled by the U.S. Chamber of Commerce, 41 percent of West Virginia doctors said that the inability of the state's poor resident to pay fees was responsible for the state's shortage of doctors, and 27 percent said that quality of life in the state was responsible.[8]

- **There is no relationship between the level of increase in liability insurance premiums and the likelihood of discontinuing obstetric practice.** A recent study examined whether New York obstetricians facing higher premiums for obstetric liability insurance were more likely to discontinue practicing than physicians experiencing lower increases in premiums. The study found that the decrease in doctors practicing obstetrics was associated with the length of time since receiving a medical license in New York. This relationship "very likely represents the phenomenon of physicians retiring from practice or curtailing obstetrics as they age."[9]

[1] "How practice costs wash away income," *Medical Economics*, October 25, 1999.
[2] MedPAC Transcript, Public Meeting, December 12, 2002.
[3] National Practitioner Data Bank, 2001 Annual Report.
[4] U.S. Chamber of Commerce, State Liability Systems Ranking Study, January 11, 2002.
[5] Public Citizen used multiple regression analysis to determine what factors are important in determining the number of doctors in a state. Per Morgan & Morgan, Health Care State Rankings 2001 the number of doctors per 100,000 residents varies between 601 in the District of Columbia to 144 in Idaho. (The national rate is 221.)
[6] Inquiry to U.S. Census statistics, percent of states' households earning $200,000 or more.
[7] *Best Places to Live,* CNN/Money (Nov. 24, 2002) <http://money.cnn.com/best/bplive/>.
[8] U.S. Chamber of Commerce, Malpractice Liability in West Virginia, January 13, 2003.
[9] Grumbach, et al, Charges for Obstetric Liability Insurance and Discontinuation of Obstetric Practice in New York, The Journal of Family Practice, Vol. 44, No. 1 (Jan. 1997) at 61.

The Bush Administration Says: "Patient Safety is Jeopardized"

"In its recent report, "To Err is Human," the Institute of Medicine (IOM) observed that, "[R]eporting systems are an important part of improving patient safety and should be encouraged. These voluntary reporting systems [should] periodically assess whether additional efforts are needed to address gaps in information to improve patient safety... However, as the IOM emphasized, fear that information from these reporting systems will be used to prepare a lawsuit against them, even if they are not negligent, deters doctors and hospitals from making reports."

The Facts: Patient safety is enhanced by the tort system; it would be further enhanced by increased regulation of doctors.

- **The Administration's own Council of Economic Advisors said the opposite last year—the tort system *increases* patient safety.** Even the conservative appointees to the President's Council of Economic Advisors admit, "a patient purchasing a medical procedure, for example, may be unlikely to fully understand the complex risks, costs and benefits of that procedure relative to others. Such a patient must turn to a physician who serves as a "learned intermediary," though there remains the problem that the patient may also not be able to judge the skill of the physician from whom the procedure is "purchased." In such a case, the ability of the individual to pursue a liability lawsuit in the event of an improper treatment, for example, provides an additional incentive for the physician to follow good medical practice. Indeed, from a broad social perspective, this may be the least costly way to proceed – less costly than trying to educate every consumer fully. In a textbook example, recognition of the expected costs from the liability system causes the provider to undertake the extra effort or care that matches the customer's desire to avoid the risk of harm. This process is what economists refer to as 'internalizing externalities.' In other words, the liability system makes persons who injure others aware of their actions, and provides incentives for them to act appropriately."[1]

- **Patient safety is at risk from medical providers' failure to commit to reducing medical errors.** In 1999 the Institute of Medicine released its report on patient safety in the U.S. The report estimated that between 44,000 and 98,000 Americans die annually as a result of preventable medical errors.[2] The IOM recommended creation of a nationwide *mandatory* reporting system of serious errors – those that result in death or serious harm – for hospitals, other institutional providers and ambulatory care systems. The IOM argued that such a system is necessary to hold providers accountable for maintaining safety and to implement safety systems that reduce the likelihood of such events occurring. IOM also recommended that health professional licensing conduct periodic re-examinations and re-licensing of doctors, nurses, and other key providers, based on both competence and knowledge of safety practices. Neither of these recommendations has been implemented, due to opposition from the medical community; nor are they mentioned in the HHS report.

- **Patient safety is also at risk from incompetent doctors.** Five percent of doctors are responsible for 54 percent of malpractice in the U.S., according to records in the National Practitioner Data Bank, maintained by HHS. An inquiry to this database, which covers malpractice judgments and settlements since September 1990, found that 5.1 percent of doctors (35,009) have paid two or more malpractice awards to patients. These doctors are responsible for 54 percent of all payouts reported to the Data Bank. Of these, only 7.6 percent have ever been disciplined by state medical boards. Even physicians who have made 5 payouts have been disciplined at only a 13.3 percent rate.

[1] "Who Pays for Tort Liability Claims? An Economic Analysis of the U.S. Tort Liability System" Council of Economic Advisers, April 2002.
[2] Institute of Medicine, To Err Is Human (1999)

The Bush Administration Says: "Health Care Costs are Increased"

"The litigation and malpractice insurance problem raids the wallet of every American. Money spent on malpractice premiums (and the litigation costs that largely determine premiums) raises health care costs. The litigation system also imposes large indirect costs on the health care system. Defensive medicine that is caused by unlimited and unpredictable liability awards not only increases patients' risk but it also adds cost…The leading study estimates that limiting unreasonable awards for non-economic damages could reduce health care costs by 5-9% without adversely affecting quality of care. This would save $60-108 billion in health care costs each year."

The Facts: The Congressional Budget Office (CBO) says that limiting liability would have a negligible impact on health care costs.

- **In evaluating the impact of H.R. 4600, which would have severely limited the ability of patients to recover damages, the Congressional Budget Office projected only minimal savings.** This bill, which contained very stringent restrictions on patients' ability to recover damages, passed the U.S. House in 2002. CBO said: "The percentage effect of H.R. 4600 on overall health insurance premiums would be far smaller than the percentage impact on medical malpractice insurance premiums. Malpractice costs account for a very small fraction of total health care spending; even a very large reduction in malpractice costs would have a relatively small effect on total health plan premiums. In addition, some of the savings leading to lower medical malpractice premiums--those savings arising from changes in the treatment of collateral-source benefits--would represent a shift in costs from medical malpractice insurance to health insurance. Because providers of collateral-source benefits would be prevented from recovering their costs arising from the malpractice injury, some of the costs that would be borne by malpractice insurance under current law would instead be borne by the providers of collateral-source benefits. Most such providers are health insurers."

- **The Congressional Budget Office has rejected the "defensive medicine" theory.** CBO was asked to quantify the savings from reduced "defensive medicine" if Congress passed H.R. 4600. CBO declined, saying:

  > Estimating the amount of health care spending attributable to defensive medicine is difficult. Most estimates are speculative in nature, relying, for the most part, on surveys of physicians' responses to hypothetical clinical situations, and clinical studies of the effectiveness of certain intensive treatments. Compounding the uncertainty about the magnitude of spending for defensive medicine, there is little empirical evidence on the effect of medical malpractice tort controls on spending for defensive medicine and, more generally, on overall health care spending.
  >
  > A small number of studies have observed reductions in health care spending correlated with changes in tort law, but that research was based largely on a narrow part of the population and considered only hospital spending for a small number of ailments that are

disproportionately likely to experience malpractice claims. Using broader measures of spending, CBO's initial analysis could find no statistically significant connection between malpractice tort limits and overall health care spending. Although the provisions of H.R. 4600 could result in the initiation of fewer lawsuits, the economic incentives for individual physicians or hospitals to practice defensive medicine would appear to be little changed.[1]

- **Overall tort expenditures are less than the cost of medical injuries.** Because so few medical injuries result in compensation to patients, the overall expenditures made for medical liability are far below the projected injury costs. The Institute of Medicine estimated the costs of preventable medical injuries in hospitals alone at between $17 billion and $29 billion a year.[2] The Utah Colorado Medical Practice study estimated it at $20 billion.[3] By contrast, the National Association of Insurance Commissioners reports that the total amount spent on medical malpractice insurance in 2000 was $6.4 billion.[4] This is at least three to five times less than the cost of malpractice to society.

- **A leading actuary says the HHS report's numbers are "rubbish."** According to Robert Hunter, Director of Insurance for Consumer Federation of America, "The total cost of medical malpractice premiums is $6.4 billion (not just for doctors, as the report says, but for doctors, hospitals and other facilities). This represents about one-half of a percent of total health care expenses. In other words, if an outright ban were placed on medical malpractice lawsuits the total savings would be about $6 billion. The idea that a cap of any kind can save $60 to $108 Billion is pure rubbish. How in the world could 'defensive medicine' possibly be more than equal to the total risk measured in premiums, much less 10 to 20 times the risk, as HHS assumes? This makes no economic sense at all."[5]

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[1] Congressional Budget Office Cost Estimate, H.R. 4600, September 24, 2002.
[2] Institute of Medicine, To Err is Human (2000).
[3] Studdert et al, "Beyond Dead Reckoning: Measures of Medical Injury Burden, Malpractice Litigation, and Alternative Compensation Models from Utah and Colorado," 33 Ind. L. Rev. 1643 (2000).
[4] NAIC, *Statistical Compilation of Annual Statement Information for Property/Casualty Insurance Companies in 2000* (2001).
[5] Robert Hunter letter to President George Bush, July 30, 2002.

The Bush Administration Says: "The Increasingly Unpredictable, Costly, and Slow Litigation System is Responsible"

"Insurance premiums are largely determined by the expensive litigation system... Its application is unpredictable, largely random, and standardless... Although most cases do not actually go to trial, it costs a significant amount of money to defend each claim--an average of $24,669... Awarded on top of compensation for the injured patient's actual economic loss, non-economic damages are said to be compensation for intangible losses, such as pain and suffering, loss of consortium, hedonic (loss of the enjoyment of life) damages, and various other theories that are imaginatively created by lawyers to increase the amount awarded... The average award rose 76% from 1996-1999. The median award in 1999 was $800,000, a 6.7% increase over the 1998 figure of $750,000; and between 1999 and 2000, median malpractice awards increased nearly 43%."

The Facts: The medical malpractice litigation process is logical, and awards are explained by income, cost of health care, and injury severity.

- **Government data show that medical malpractice awards have increased at a much slower pace than claimed by Jury Verdict Research.** According to the federal government's National Practitioner Data Bank (NPDB), the median medical malpractice payment by a physician to a patient rose 35 percent from 1997 to 2001, from $100,000 to $135,000.[1] By contrast, data from Jury Verdict Research (JVR), a private research firm, which was cited in the HHS report shows that awards rose 100 percent from 1997 to 2000, from $503,000 to $1 million.[2] The reason for the huge difference, which is explained in more detail below: JVR collects only jury *verdict* information that is reported to it by attorneys, court clerks and stringers. The NPDB is the most comprehensive source of information that exists because it includes both verdicts *and* settlements. Ninety-six percent of all medical malpractice cases are settled, as opposed to decided by a jury, and settlements result in much lower awards than jury verdicts.[3] Jury verdicts are higher than the average settlement because cases involving severe injuries are more likely to go to trial, and the defendant has usually rejected a settlement offer for a much smaller amount. JVR reported that the median final plaintiff demand in 2000 was $562,000, and the median final settlement offer from the doctor was $80,000. Thus, in the twenty percent of trials that doctors lost, a conscious decision was made to risk a much higher jury verdict. The plaintiffs were usually willing to settle for about half of what the jury awarded. According to NPDB's database of all medical malpractice settlements and judgments, the median payment in a settlement in 2000 was $125,000, same as the median for all payments; but the median payment for a judgment was $235,000. This figure is lower than the jury verdict figure because the ultimate payment received by a successful plaintiff reflects remittiturs ordered by judges, and discounts agreed to by plaintiffs in order to avert appeals.

- **Government data show that medical malpractice awards have increased at a slower pace than health insurance premiums.** While NPDB data show that the median medical malpractice payment rose 35 percent from 1997 to 2001 (an average of 8.5 percent a year), the average premium for single health insurance coverage increased 39 percent over that time period (9.5 percent a year).[4] Payments for health care costs, which

directly affect health insurance premiums, make up the lion's share of most medical malpractice awards.

- **"Non-economic" damages are not as easy to quantify as lost wages or medical bills, but they compensate real injuries.** So-called "non-economic" damages are awarded for the pain and suffering that accompany any loss of normal functions (e.g. blindness, paralysis, sexual dysfunction, lost bowel and bladder control) 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. The fact that Americans spend a great deal of money to remedy these conditions (e.g. on pain relief medication, reconstructive surgery, etc.) belies any notion that such damages are "non-economic." According to Physician Insurer Association of America (PIAA), the average payment between 1985 and 2001 for a "grave injury," which encompasses paralysis, was only $454,454.[5]

- **No evidence supports the claim that jury verdicts are random "jackpots."** Studies conducted in California, Florida, North Carolina, New York, and Ohio have found that jury verdicts bear a reasonable relationship to the severity of the harm suffered.[6] In total the studies examined more than 3,500 medical malpractice jury verdicts and found a consistent relationship between the severity of the injury and the size of the verdict. Uniformly the authors concluded that their findings did not support the contention that jury verdicts are frequently unpredictable and irrational.

- **The insurance industry's own numbers demonstrate that awards are proportionate to injuries.** PIAA's Data Sharing Report also demonstrates the relationship between the severity of the injury and the size of the settlement or verdict.[7] PIAA, as do most researchers, measures severity of injury according to the National Association of Insurance Commissioners' classifications.[8] The average indemnity paid per file was $49,947 for the least severe category of injury and increased with severity, to $454,454 for grave injuries. All researchers found that the amount of jury verdicts fell off in cases of death, for which the average indemnity was $195,723. This is not surprising, as the costs of medical treatment for a grave injury are likely to be greater and pain and suffering would be experienced over a longer time period than in the case of death.[9]

- **The contingency fee system discourages attorneys from bringing frivolous claims.** Medical malpractice cases are brought on a contingency fee basis, meaning the attorney receives payment only in the event there is a settlement or verdict. If the claim is closed without payment, the attorney does not receive a fee. Since attorneys must earn money to stay in business, it follows that they would not intentionally take on a non-meritorious case.

- **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.[10] If the case goes to trial, the costs can easily be doubled.[11] 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. An attorney incurs expenses beginning with the determination of whether a case has

merit. First, the attorney is required to obtain copies of the patient's medical records from all the providers for analysis by a competent medically trained person. If that initial consultation reveals a likelihood of medical negligence, the records must then be submitted to medical specialists, qualified to testify in court, for final review. Typically, the records must be sent to experts outside of the plaintiff's state, as physicians within the state will refuse to testify against local colleagues. As a result, the experts who agree to review records and testify can and do charge substantial fees. Fees from $1,000 per hour to several thousand dollars are not uncommon.[12] Discovery involves taking the sworn testimony of witnesses and experts. Such depositions cost $300 and up, depending upon their length and complexity. If an expert witness is deposed, the plaintiff's attorney is charged for the witness' preparation time and time attending the deposition.

- **Plaintiffs drop 10 times more claims than they pursue.** PIAA reports that between 1985 and 2001 a total of 108,300 claims were "dropped, withdrawn or dismissed." This is 63 percent of the total number of claims (172,474) closed during the study period.[13] It is unclear what portion constitutes involuntarily dismissed cases (dismissed after a motion was filed by the defendant) rather than cases voluntarily dismissed by plaintiffs. According to researchers at the University of Washington School of Medicine, about nine percent of claims files are closed after the defendant wins a contested motion[14] Based on this figure, Public Citizen estimates that about 54 percent of claims are being abandoned by patients.[15] An attorney may send a statutorily-required notice of intent to claim or file a lawsuit in order to meet the requirements of the statute of limitations but, after collecting medical records and consulting with experts, decide not to pursue the claim. We estimate that the number of cases withdrawn voluntarily by plaintiffs[16] was 92,621, *10 times* the number of cases that were taken to trial and lost during that period (9,293). The percentage of claims pursued by plaintiffs to final rejection by a jury is only *five percent*.[17]

- **The small number of claims pursued to a defense verdict are not frivolous.** Researchers at the American Society of Anesthesiologists arranged for pairs of doctors to review 103 randomly selected medical negligence claims files.[18] The doctors were asked to judge whether the anesthesiologist in question had acted reasonably and prudently. The doctors only agreed on the appropriateness of care in 62 percent of the cases; they disagreed in 38 percent of cases. The researchers concluded, "These observations indicate that neutral experts (the reviews were conducted in a situation that did not involve advocacy or financial compensation) commonly disagree in their assessments when using the accepted standard of reasonable and prudent care." The percentage of all medical malpractice claims that go to trial is only 6.6 percent, according to PIAA, meaning that the parties and their attorneys ultimately reach agreement about liability five times more often than neutral doctors do. If truly frivolous lawsuits were being pursued, the proportion of claims going to trial would exceed the 38 percent of claims on which even doctors will disagree.

- **The costs of defending claims that are ultimately dropped are not unreasonable.** Medical liability insurers have complained about the costs of defending cases that are ultimately dropped. But the professional obligation of lawyers to exercise due diligence is essentially identical to the duty of physicians. The lawyer must rule out the possibility of proving medical negligence before terminating a claim, just as doctors must rule out the possibility of illnesses suggested by their patients' symptoms. The doctor

performs his duty by administering tests; the lawyer performs hers by using discovery procedures. Both processes can lead to dead ends. But plaintiffs' lawyers have no financial incentive to abuse the litigation process: they are using their own time and money to pursue discovery activities, and are only paid for work on behalf of clients whose cases are successful.

- **Award amounts correlate to plaintiff's income and the cost of living in the plaintiff's home state.** Median malpractice awards vary from state to state. Much of the variation is explained by two factors—median family income and urbanization. Public Citizen's analysis of NPDB[19] and census data[20] found that for every $1,000 increase in a state's median family income, the median award amount increases by about $1,100. Our analysis also found that awards increase in relation to state population density—logical, since urbanized areas have a higher cost of living than rural areas.

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[1] National Practitioner Data Bank Annual Reports, 1997 through 2001.
[2] Jury Verdict Research, "Medical Malpractice: Verdicts, Settlements and Statistical Analysis," 2002.
[3] Physician Insurer Association of America, Claim Trend Analysis, 2001 Edition
[4] Kaiser Family Foundation and Health Research and Educational Trust, Employer Health Benefits Surveys, 1998-2002; National Practitioner Data Bank Annual Reports, 1997 through 2001.
[5] PIAA Claim Trend Analysis, 2001 Ed.
[6] Kelso & Kelso, *Jury Verdicts in Medical Malpractice Cases and the MICRA Cap*, Institute for Legislative Practice (1999). Vidmar N, Gross F, Rose M, "Jury Awards for Medical Malpractice and Post-Verdict Adjustments of Those Awards", 48 *DePaul Law Review* 265 (1998). Merritt & Barry, "Is the Tort System In Crisis? New Empirical Evidence," 60 *Ohio State Law Journal* 315 (1999).
[7] *PIAA Data Sharing Report*, Report 7, Part 10.
[8] The NAIC scale grades injury severity as follows: Emotional damage only (fright; no physical injury);
Temporary insignificant (lacerations, contusions, minor scars);
Temporary minor (infections, fall in hospital, recovery delayed);
Temporary major (burns, surgical material left, drug side-effects);
Permanent minor (loss of fingers, loss or damage to organs);
Permanent significant (deafness, loss of limb, loss of eye, kidney or lung);
Permanent major (paraplegia, blindness, loss of two limbs, brain damage);
Permanent grave (quadriplegia, severe brain damage, lifelong care or fatal prognosis);
Death
[9] Vidmar, Gross, Rose, supra at 284
[10] Based on Public Citizen interviews with plaintiff attorneys.
[11] See Vidmar, Medical Malpractice and the American Jury (1995).
[12] According to the Physician Insurers Association of America, expert witnesses in a medical malpractice case are paid on average over $4,800.
[13] *Trend Analysis Report*, 2001 Edition, 6b-4
[14] Rosenblatt & Hurst, "An Analysis of Closed Obstetric Malpractice Claims," 74 *Obstetrics & Gynecology* 710 (1989).
[15] Another study, Sloan et al, *Suing for Medical Malpractice*, (1993) found the number was 5.9 percent, not nine percent. According to our queries to the database of Federal District Court Civil Cases, maintained by Professors Theodore Eisenberg and Kevin Clermont, about 4.7 percent of 10,075 medical malpractice cases between 1987 and 1992 were disposed of by pre-trial motion. To make a conservative estimate, however, we are going to use the nine percent figure.y
[16] .09 times 172,474 equals 15,679; subtracted from 108,300 equals 92,621 claims voluntarily withdrawn.
[17] 9,293/172,474=.054
[18] Posner et al, "Variation in expert opinion in medical malpractice review," 85 *Anesthesiology* 1049 (1996).
[19] Cumulative Median Payment, 1990-2000, NPDB Annual Report 2000.
[20] Median Income For 4-Person Families, By State, *Federal Register*, January 30, 2002.

The Bush Administration Says: "Insurance Premiums are Rising Rapidly"

"The cost of the excesses of the litigation system shows up in the cost of malpractice insurance coverage. Premiums have increased rapidly over the past several years."

The Facts: The Spike in Medical Liability Premiums Was Caused by the Insurance Cycle, Not by an "Explosion" of Lawsuits or "Skyrocketing" Jury Verdicts

- **There is no growth in the number of new medical malpractice claims.** According to the National Association of Insurance Commissioners (NAIC), the number of new medical malpractice claims declined by about four percent between 1995 and 2000. There were 90,212 claims filed in 1995; 84,741 in 1996; 85,613 in 1997; 86,211 in 1998; 89,311 in 1999; and 86,480 in 2000.[1]

- **For much of the 1990s, doctors benefited from artificially lower premiums.** According to the International Risk Management Institute (IRMI), one of the leading analysts of commercial insurance issues, "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."[2]

- **West Virginia Insurance Commissioner blames the market.** According to the Office of the West Virginia Insurance Commission (one of the states in the throes of a medical malpractice "crisis"), "[T]he insurance industry is cyclical and necessarily competitive. We have witnessed these cycles in the Medical Malpractice line in the mid-'70's, the mid-80's and the present situation. This particular cycle is, perhaps, worse than previous cycles as it was delayed by a booming economy in the '90's and is now experiencing not just a shortfall in rates due to competition, but a subdued economy, lower interest rates and investment yields, the withdrawal of a major medical malpractice writer and a strong hardening of the reinsurance market. Rates will, at some point, reach an acceptable level to insurers and capital will once again flow into the Medical Malpractice market."[3]

- **Medical liability premiums track investment results.** J. Robert Hunter, one of the country's most knowledgeable insurance actuaries and director of insurance for the Consumer Federation of America, recently analyzed the growth in medical liability premiums.[4] He found that premiums charged do not track losses paid, but instead rise and fall in concert with the state of the economy. When the economy is booming and investment returns are high, companies maintain premiums at modest levels; however, when the economy falters and interest rates fall, companies increase premiums in response.

- **The same trends are present in other lines of insurance.** Property/casualty refers to a large group of liability lines of insurance (30 in total) including medical malpractice, homeowners, commercial, and automobile. 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 the down phase of the cycle, as results deteriorate, the basic ability of insurance companies to underwrite new business or, for some companies even to renew some existing policies, can be impaired. This is because the capital needed to support the underwriting of risk has been depleted through losses. The current market began to harden in 2001, following an unusually prolonged period of soft market conditions in the property-casualty section in the 1990s. The current hard market is unusual in that many lines of insurance are affected at the same time, including medical malpractice. As a result, premiums are rising for most types of insurance. The increases have taken policyholders by surprise given that they came after several years of relatively flat to decreasing prices.[5]

- **Insurer mismanagement compounded the problems.** Compounding the impact of the cycle has been misleading accounting practices. As the *Wall Street Journal* found in a front page investigative story on June 24, 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."[6] Moreover, "In at least one case, aggressive pricing allegedly crossed the line into fraud." According to Donald J. Zuk, chief executive of SCPIE Holdings Inc., a leading malpractice insurer in California, "Regardless of the level of … tort reform, the fact remains that if insurance policies are consistently under-priced, the insurer will lose money."[7]

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[1] National Association of Insurance Commissioners, Statistical Compilation of Annual Statement Information for Property/Casualty Insurance Companies in 2000 (2001).
[2] Kolodkin, Charles, "Medical Malpractice Insurance Trends? Chaos!" International Risk Management Institute. http://www.irmi.com/expert/articles/kolodkin001.asp
[3] State of West Virginia Medical Malpractice Report on Insurers with over 5% Market Share, Provided by the Office of the West Virginia Insurance Commission, November 2002.
[4] Americans for Insurance Reform, "Medical Malpractice Insurance: Stable Losses/Unstable Rates," October 10, 2002. See also: http://www.insurance-reform.org/StableLosses.pdf.
[5] Hot Topics & Insurance Issues, Insurance Information Institute, www.iii.org
[6] Christopher Oster and Rachel Zimmerman, "Insurers' Missteps".
Helped Provoke Malpractice 'Crisis,'" *Wall Street Journal*, June 24, 2002.
[7] Charles Kolodkin, Gallagher Healthcare Insurance Services, "Medical Malpractice Insurance Trends? Chaos!" ((September 2001), found at http://www.irmi.com/expert/articles/kolodkin001.asp.

The Bush Administration Says: "Insurers are Leaving the Market"

"The litigation crisis is affecting patients ability to get care not only because many doctors find the increased premiums unaffordable but also because liability insurance is increasingly difficult to obtain at any price, particularly in non-reform states. Demonstrating and exacerbating the problem, several major carriers have stopped selling malpractice insurance."

The Facts: At least three of the four insurance companies identified by HHS as leaving the market had serious management problems during the past two years.

- **PHICO had been placed under the supervision of insurance regulators and was later sued by the state's Insurance Department.** The lawsuit alleged that PHICO directors ignored signs of financial trouble at the company and pressured the board to pay dividends at a time when the insurer's surplus "was declining drastically and significant strengthening of loss reserves was required."[1]

- **St. Paul exited other insurance markets as well.** St. Paul Companies reported in December 2001 that it had $85 million in exposure as related to the Enron Corporation and that it held approximately $23 million in Enron Corporation senior unsecured debt. At the same time St. Paul announced it would exit its medical malpractice business, it also announced it would add reserves for claims related to the September 11 terrorist attacks, "exit certain reinsurance lines, exit countries where the company is not likely to achieve competitive scale, and reduce corporate overhead expenses, including staff reductions."[2]

- **MIIX was found by Weiss Ratings to be the hardest hit by the property and casualty insurance industry's overall $6.6 billion decline in investment gains during the first half of 2002.** MIXX reported the largest capital losses.[3] Weiss, a leading independent provider of ratings and analyses of financial services companies, downgraded MIIX from D- to E+, E being the lowest score possible. A former MIIX official has alleged conflicts of interest on the company's board that may have affected the situation.[4]

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[1] Associated Press, "Malpractice-panel member cited in suit," *Philadelphia Inquirer*, Nov. 23, 2002.
[2] St Paul Companies Inc. Form 8-K filed with Securities and Exchange Commission, December 19, 2001
[3] Business Wire, *Property and Casualty Insurers Suffer $6.6 Billion Decline in Investment Gains during the First Half of 2002, Reports Weiss Ratings; Premium Rate Increases Sustain Industry Earnings*, January 13, 2003.
[4] "Ex-Employee Sues Medical Society, Cites Insurer Ties," The Legal Intelligencer, December 16, 2002.

The Bush Administration Says: "States with Realistic Limits on Non-Economic Damages Are Faring Better"

"The insurance crisis is less acute in states that have reformed their litigation systems. States with limits of $250,000 or $350,000 on non-economic damages have average combined highest premium increases of 12-15%, compared to 44% in states without caps on non-economic damages, as shown in Table 5…"

The Facts: Neither the HHS report nor anyone else has presented a factual case that caps lower premiums; Public Citizen's analysis found that premiums are higher in states with caps.

- **The HHS report's "comparison" of premiums in ten states with caps to just ten states without caps is pure baloney.** HHS omitted data from other states without damage caps that did not have high premium increases. The Pennsylvania Medical Society last week released a critique of another premium comparison, concluding that "Multivariate modeling must be used to control for outside influences… An issue as important as liability insurance reform deserves no less than a careful scientific approach to assessment of the impact of policy changes."[1] While they did not prepare a multivariate model, Public Citizen did.

- **Public Citizen's analysis finds that, controlling for other factors, premiums are higher in states with caps than in states without caps.** Public Citizen entered U.S. Census[2], NPDB[3], and Medical Liability Monitor[4] data into a multiple regression model to determine the effect that damage caps have on awards and on doctors' liability insurance premiums. Our preliminary finding is that a damage cap lowers the median payment made by doctors to plaintiffs by $29,000, in turn lowering a doctor's premium by about $11,000. Nevertheless, controlling for this and the rate of lawsuits against doctors in each state, states with caps still have premiums that are $14,000 higher than in states without caps, a $3,000 net increase. We believe that the cap encourages doctors to take more cases to trial, and the resulting higher defense attorney costs more than offset the lower indemnity payments.

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[1] Pennsylvania Medical Society, "Critique of Center for Justice and Democracy Study by J. Robert Hunter and Joanne Doroshow," January 8, 2003.
[2] Median Income For 4-Person Families, By State, *Federal Register*, January 30, 2002.
[3] Cumulative Median Payment, 1990-2000, NPDB Annual Report 2000.
[4] Median premium for general surgeon, reported in Medical Liability Monitor Special Report, Trends in 2002 Rates for Physicians' Medical Professional Liability Insurance, October 2002.