

Increasing Doctor Accountability & Patient Safety:

Solving Georgia's Medical Malpractice "Crisis"



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Acknowledgments

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Executive Summary

The American Medical Association (AMA) has included Georgia on the list of states it claims are experiencing a “crisis” when it comes to the malpractice liability system. It is understandable that doctors and some legislators are concerned by increases in medical malpractice insurance premiums. Nobody wants to see physicians forced to pay significantly more to insure themselves, even if they are highly-paid specialists who earn hundreds of thousands of dollars a year. It is essential, however, that discussions of public policy and attempts to address the issue of medical liability insurance be based on solid facts, not a false sense of “crisis” generated to serve interest groups seeking to reduce their exposure to lawsuits.

The strident tone used to discuss medical malpractice issues in Georgia mirrors comments made on the national level, including claims by Washington politicians – that “junk and frivolous lawsuits” have become “one of the major cost drivers in the delivery of health care.” In fact, the costs of medical malpractice insurance represent just 0.62 percent of the nation’s health care expenditures.¹

The AMA and the Medical Association of Georgia advocate a \$250,000 cap on the amount that injured patients can receive for a lifetime of pain and suffering, known as non-economic damages. Such a cap, which has not been proven to effectively lower medical malpractice insurance costs, would penalize only the most severely injured patients while reducing medical accountability, thereby lessening deterrence against errors and negligence.

This report makes three main points:

- The most significant malpractice crisis faced by Georgians is that of quality of care: Medical malpractice and mistakes cost Georgia’s families and communities dearly. Moreover, a small number of doctors are causing a disproportionately large percentage of all the medical malpractice payouts in Georgia, and most of those doctors are going undisciplined.
- Rather than working to limit patients’ legal rights, the vast majority of competent, conscientious doctors could join with patients and consumers in efforts to dramatically reduce medical malpractice and mistakes and improve physician oversight in Georgia – thereby improving safety and bringing down malpractice insurance rates in the long-term.
- The short-term spike in malpractice insurance rates is due to the economics of the insurance marketplace – not lawsuits and the legal system. In response to rate hikes, it would be a tragedy to reduce patients’ long-term legal rights.

This study, which relies on statistics from numerous government agencies and other objective sources, has these key findings:

- **Georgia’s patients and consumers suffer the real costs of medical malpractice.** The true impact of medical malpractice in Georgia should be measured by the cost to patients and consumers, not the premiums paid by doctors and other health care providers to insurance companies. Extrapolating from the Institute of Medicine findings, we estimate that there are at least 1,276 to 2,842 preventable deaths in Georgia hospitals each year that are due to preventable medical errors. The cost of preventable medical errors in hospitals to Georgia’s residents, families and communities is estimated at \$493 million to \$841 million each year. But the cost of medical malpractice insurance to Georgia’s health care providers is only \$200.6 million a year.
- **3.5 percent of doctors are responsible for nearly 40 percent of Georgia’s medical malpractice payouts.** According to the federal government’s National Practitioner Data Bank, just 3.5 percent of Georgia’s doctors have been responsible for 39.2 percent of all malpractice payouts to patients. And just 1 percent of Georgia doctors, each of whom has paid three or more malpractice claims, were responsible for 15.5 percent of all payouts.
- **The vast majority of doctors have no record of malpractice payouts.** In Georgia, 84.9 percent of doctors have not made a medical malpractice payout since September 1990, when the NPDB was created. Yet, virtually all Georgia doctors are paying the price for the medical errors of the few.
- **Doctors with repeated malpractice claims against them suffer few consequences.** Only 8.1 percent of Georgia doctors who made two or more malpractice payouts were disciplined by the Georgia Medical Board, according to the NPDB. Only 13.8 percent of doctors who made three or more malpractice payouts were disciplined. And only 24.2 percent who made four or more malpractice payouts were disciplined.
- **18 physicians in Georgia have made between four and eight malpractice payouts, but have not been disciplined.** The alarming extent to which Georgia doctors make multiple payouts to patients for medical malpractice claims and are not disciplined is illustrated by the cases of 18 physicians licensed in Georgia who have made between four and eight malpractice payouts – totaling more than \$1 million in payouts for each doctor – yet have not been disciplined by the State Medical Board. Collectively, these 18 physicians have been responsible for 90 medical malpractice payments to patients totaling nearly \$50 million.
- **American Medical Association’s rankings demonstrate link between poor quality of medical care and so-called “malpractice crises” in some states – including Georgia.** In 2002, the American Medical Association (AMA) designated 12 states – including Georgia – as having “liability systems in crisis.” And when the *Journal of the American Medical Association* published rankings of states’ quality of health care in January 2003, the truth became apparent: Nine of the 12 “crisis” states ranked at the bottom in quality of care in 2000-2001 (latest available data). Georgia’s rank was 47th.

- Georgia should take the lead in funding a patient safety program to reduce medical negligence and malpractice insurance costs.** In 1973, a blue ribbon commission appointed by the U.S. Department of Health, Education and Welfare (HEW) recommended that malpractice insurers dedicate a portion of each premium dollar to the study of malpractice incidents and creation of medical malpractice prevention programs. Georgia could take this kind of action on the state level by mandating a one-time 1 percent surcharge on malpractice insurance premiums to fund a Claims Analysis Project. Such an assessment would yield about \$2 million in seed money to start the program, perhaps at a medical school in Georgia. A 0.5 percent surcharge each year thereafter could provide operating expenses. The claims analysis could be conducted and standards voluntarily adopted to reduce the incidence of medical malpractice. The result would be a win-win for patients and physicians – safer medical care and the lower premiums that it will bring.
- Anesthesiologists’ experience shows patient safety efforts do more than caps to reduce lawsuits and insurance premiums.** In 1985, the American Society of Anesthesiologists studied malpractice files from 35 different insurers and issued standards and procedures to avoid injuries. The resulting savings exceeded the dreams of any “tort reformer.” 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. From the 1970s to the 1990s, anesthesiology claims involving permanent disability or death dropped from 64 percent to 41 percent, and claims resulting in payments to plaintiffs dropped from 64 percent to 45 percent. 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). And the safety effort dramatically reduced awards. For example, during the 1990s, the median malpractice award in California, which has a stringent \$250,000 cap on non-economic damages, increased by 103 percent, but the median anesthesiology malpractice award remained constant.
- Claims that malpractice insurance costs are driving doctors out of Georgia are based on the same kinds of biased surveys the General Accounting Office has declared unreliable in other states.** The GAO, Congress’ watchdog agency, compared conditions in five AMA-designated “crisis states,” including Florida, 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. Claims of a “crisis” by Georgia doctors likewise are based on two biased surveys conducted by agencies that are controlled by doctors. These surveys were worded in ways that made the results a foregone conclusion – and the resulting reports do not give an accurate accounting of the numbers of doctors practicing in the state or of the state of the health care system.
- California’s lower malpractice insurance premiums are due to insurance reforms, not damage caps.** In 1975 California passed MICRA (Medical Injury Compensation Reform Act), the centerpiece of which is a \$250,000 cap on non-economic damages. Ever since, this has been the model law for efforts to restrict patients’ legal rights in other states. Ironically, the California experience exemplifies the success of insurance

reforms, not the imposition of damage caps, at keeping malpractice rates lower. In a revolt against skyrocketing auto and homeowners insurance rates, voters passed Proposition 103 in 1988. This strong pro-consumer measure, which also applied to lines of medical malpractice insurance, instituted a 20 percent rate rollback and made it much more difficult for companies to get future rate increases. The effect on medical-malpractice insurance premiums was staggering. In the first 12 years of MICRA (1976-1988) premiums paid *increased* 190 percent, but under Proposition 103 premiums paid *declined* 2 percent from 1988-2001.

- **Caps on damages are a false “solution.”** Doctors and their lobbyists in Georgia are pushing for a \$250,000 limit on non-economic damages, also known as “pain-and-suffering,” in medical malpractice cases. Such a cap, widely promoted by medical associations and their political allies, has not been proven to effectively lower medical malpractice insurance costs. It does, however, penalize the most severely injured patients while reducing physician, hospital and HMO accountability, thereby lessening deterrence against errors and negligence.
- **A cap on non-economic damages effects only the most seriously injured patients.** A cap on non-economic damages is cruel and unusual punishment, because it affects only those who are most catastrophically harmed. According to Physician Insurers Association of America (PIAA), the average total payment between 1985 and 2001 for a “grave injury,” which encompasses paralysis, was only \$454,454. This includes both economic damages (health care costs and lost wages) and non-economic damages. Since about one-third to one-half of a total award comprises non-economic damages, a \$250,000 cap affects only patients with “grave injuries.”
- **Capping awards hurts children, women, seniors and minorities in particular.** Limiting medical malpractice awards for non-economic injury has a disproportionate impact on children, women, seniors and minorities. Children have no employment income, which is the basis for calculating most economic awards. One of the more significant medical injuries inflicted on women is harm to reproductive capacity, but that does not impact a woman’s earning capacity, and thus does not entitle her to economic damages despite the devastating emotional impact of such a loss. Retired seniors who suffer often deplorable neglect and abuse in nursing homes and other long-term care facilities have no employment income. Capping awards also discriminates against minorities since they have lower incomes on average than whites. In some cases, low wage earners are denied the opportunity to earn more in the future due to injuries caused by medical negligence.
- **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. 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 criticism that jury verdicts are frequently unpredictable and irrational.

- **The insurance industry's own statistics demonstrate that awards are proportionate to injuries.** The PIAA Data Sharing Report also demonstrates the relationship between the severity of an injury and the size of the settlement or verdict. PIAA, as do most researchers, measures severity of injury according to the National Association of Insurance Commissioners' classifications. 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.

Georgia's Patients & Consumers Suffer the Real Costs of Medical Malpractice

In 1999, the Institute of Medicine (IOM) estimated that from 44,000 to 98,000 Americans die in hospitals every year from *preventable* medical errors.² The IOM also estimated the costs to individuals, their families and society at large for these medical errors at \$17 billion to \$29 billion a year. These costs include disability and health care costs, lost income, lost household production and the personal costs of care.

The true impact of medical malpractice in Georgia should be measured by the cost to patients and consumers, not the premiums paid by doctors and other health care providers to their insurance companies. Extrapolating from the IOM findings, we estimate that there are at least 1,276 to 2,842 preventable deaths in Georgia hospitals each year that are due to preventable medical errors. The costs resulting from these preventable medical errors to Georgia's residents, families and communities are estimated at \$493 million to \$841 million each year. But the cost of medical malpractice insurance to Georgia's health care providers is only \$200.6 million a year.³ [See Figure 1]

Figure 1

The Real Cost of Medical Malpractice to Georgia's Patients and Consumers v. Georgia's Health Care Providers

<p><u>1,276 - 2,842</u> Preventable Hospital Deaths Due to Medical Errors in Georgia Each Year</p>
<p><u>\$493 million - \$841 million</u> Costs Resulting from Preventable Medical Errors in Georgia Each Year</p>
<p><u>\$200.6 million</u> Cost of Georgia Health Care Providers' Annual Medical Malpractice Premiums</p>

Sources: Preventable deaths and costs are prorated based on population and based on estimates in *To Err Is Human*, Institute of Medicine, November 2000. Malpractice premiums are based on a report to National Association of Insurance Commissioners' Property and Casualty Committee, "Medical Malpractice Insurance – A Study of Market Conditions," table 13, "2002 Medical Liability Profitability Results By State," Dec. 3, 2003.

3.5 Percent of Doctors Are Responsible for Almost 40 Percent of Georgia Medical Malpractice Payouts

The insurance and medical communities have argued that medical malpractice litigation constitutes a giant “lottery,” in which lawsuits are purely random events bearing no relationship to the care given by a physician. If the tort system is a lottery, it is clearly a rigged one, because some doctors’ numbers come up more often than others. According to the federal government’s National Practitioners Data Bank (NPDB), which was created in September 1990 to track malpractice judgments and settlements, a small percentage of doctors have attracted multiple claims, and it is these doctors who are responsible for much of the malpractice in Georgia.

- According to the NPDB, just 3.5 percent of Georgia’s doctors have been responsible for 39.2 percent of all malpractice payouts to patients. [See Figure 2] Overall, these 579 doctors, all of whom have made two or more payouts, have paid \$360 million in damages since September 1990.
- Even more surprising, just one percent of Georgia doctors (159), each of whom has paid three or more malpractice claims, were responsible for 15.5 percent of all payouts.
- 84.9 percent of Georgia doctors have not made a medical malpractice payout.

Figure 2

Number of Medical Malpractice Payouts to Patients and Amounts Paid by Georgia Doctors, Sept. 1, 1990-Sept. 30, 2003

Number of Payout Reports	Number of Doctors Who Made Payouts	Total Number of Payouts	Percent/Total Doctors (16,652)*	Percent of Total Number of Payouts
All	2,522	3,190	15.1%	100.0%
1	1,943	1,943	11.7%	60.9%
2 or more	579	1,247	3.5%	39.2%
3 or more	159	496	1.0%	15.5%
4 or more	62	231	0.4%	7.2%
5 or more	33	138	0.2%	4.3%

Source: National Practitioner Data Bank, Sept. 1, 1990 – Sept. 30, 2003.

* Based on number of physicians in Georgia in 1997, the midpoint of the time period studied, as reported by the American Medical Association.

Doctors with Repeated Malpractice Claims Against Them Suffer Few Consequences

The Georgia Medical Board and the state's health care providers have done little to rein in those doctors who repeatedly make medical errors and commit medical negligence. According to the National Practitioner Data Bank and Public Citizen's analysis of NPDB data, disciplinary actions (license suspension or revocation, or a limit on clinical privileges) have been uncommon for Georgia physicians. [See Figure 3]

- Only 8.1 percent (47 of 579) of Georgia doctors who made two or more malpractice payouts were disciplined by the state's medical board.
- Only 13.8 percent (22 of 159) of Georgia doctors who made three or more malpractice payouts were disciplined by the board.
- Only 24.2 percent (15 of 62) of Georgia doctors who made four or more malpractice payouts were disciplined by the board.
- Only 30.3 percent (10 of 33) of Georgia doctors who made five or more malpractice payouts were disciplined by the board.

Figure 3

Number of Georgia Doctors with Two or More Medical Malpractice Payouts Who Have Been Disciplined (Reportable Licensure Actions), Since 1990

Number of Payout Reports	Number of Doctors Who Made Payouts	Number of Doctors with One or More Reportable Licensure Actions	Percent of Doctors with One or More Reportable Licensure Actions
2 or more	579	47	8.1%
3 or more	159	22	13.8%
4 or more	62	15	24.2%
5 or more	33	10	30.3%
10 or more	4	2	50.0%

Source: National Practitioner Data Bank, Sept. 1, 1990 – Sept. 30, 2003.

Examples of Repeat Offenders Who Have Gone Undisciplined

The extent to which Georgia doctors make multiple payouts to patients for medical malpractice claims and are not disciplined is illustrated by the following NPDB descriptions of 18 physicians licensed in Georgia who have made between four and eight malpractice payouts – totaling more than \$1 million in payouts for each doctor – yet have not been disciplined by the state.⁴ Collectively, these 18 physicians have been responsible for 90 medical malpractice payments to patients totaling nearly \$50 million:

- **Physician number 122329** made four malpractice payments between 1998 and 2002, twice for failure to make a diagnosis, once for the wrong diagnosis and once for improper management of surgery. The damages add up to \$12,890,000.
- **Physician number 84515** made four malpractice payments between 1995 and 2001, once for improper choice of delivery method and three times for unspecified obstetrics errors. The damages add up to \$7,190,000.
- **Physician number 136993** made four malpractice payments between 1999 and 2003, twice for improper management of surgery, once for improper management of medication regimen and once for a retained foreign body in surgery. The damages add up to \$3,300,000.
- **Physician number 9572** made four malpractice payments between 1992 and 2002 for improper performance of surgery, a retained foreign body in surgery, a delay in identification of fetal distress and an unspecified surgery error. The damages add up to \$2,950,000.
- **Physician number 13193** made 13 malpractice payments between 1992 and 1997, five times for improper performance of surgery, twice for unnecessary surgery, twice for unspecified errors in surgery, twice for improper performance of a treatment/procedure, once for a failure to diagnose and once for an unspecified treatment error. The damages add up to \$2,808,750.
- **Physician number 9662** made six malpractice payments between 1990 and 2003, four times for failure to diagnose, once for wrong diagnosis and once for improper performance of a treatment or procedure. The damages add up to \$2,084,500.
- **Physician number 9819** made four malpractice payments between 1993 and 2002, twice for failure to refer or seek consultation, once for delay in diagnosis and once for an unspecified treatment error. The damages add up to \$2,010,000.
- **Physician number 9968** made four malpractice payments between 1993 and 1999, twice for surgery on the wrong body part, once for improper management of a course of treatment and once for improper performance of a treatment/procedure. The damages add up to \$1,965,000.

- **Physician number 64551** made four malpractice payments between 1994 and 1998, three times for improper management of surgery and once for failure to diagnose. The damages add up to \$1,780,000.
- **Physician number 10137** made four malpractice payments between 1991 and 2001, twice for failure to diagnose, once for making the wrong diagnosis and once for an unspecified diagnosis error. The damages add up to \$1,778,750.
- **Physician number 117888** made five malpractice payments between 1998 and 2003, three times for failure to diagnose, once for making the wrong diagnosis and once for an unspecified treatment error. The damages add up to \$1,725,000.
- **Physician number 9535** made five malpractice payments between 1991 and 2003 twice for improperly performed vaginal surgery, once for improper performance of a treatment/procedure, and twice for unspecified obstetrics errors. The damages add up to \$1,540,000.
- **Physician number 9632** made five malpractice payments between 1993 and 2003 for ordering the wrong dosage of the correct medication, failure to diagnose, an unspecified diagnosis error and twice for improper performance of a treatment/procedure. The damages add up to \$1,335,000.
- **Physician number 87894** made four malpractice payments between 1997 and 2003 for delay in surgery, improper performance of surgery, an unspecified surgery error and an unspecified treatment error. The damages add up to \$1,272,500.
- **Physician number 120068** made five malpractice payments between 1998 and 2002 for failure to diagnose, improperly managed labor and three times for unspecified obstetrics errors. The damages add up to \$1,200,000.
- **Physician number 106120** made six malpractice payments between 1997 and 2003 for failure to diagnose, improper management of a course of treatment, a retained foreign body in surgery, an unspecified error in surgery and twice for improper performance of surgery. The damages add up to \$1,170,000.
- **Physician number 9805** made five malpractice payments between 1992 and 2000 for delay in treatment of identified fetal distress, failure to identify/treat fetal distress, an unspecified obstetrics error and twice for failure to manage pregnancy. The damages add up to \$1,125,000.
- **Physician number 29103** made four malpractice payments between 1992 and 2000 for improperly performed vaginal surgery, a retained foreign body in surgery and twice for unspecified surgery errors. The damages add up to \$1,090,000.

Rankings by the American Medical Association Demonstrate a Link between Malpractice “Crises” and Poor Quality of Care

In mid-2002, the American Medical Association (AMA) designated 12 states as having “liability systems in crisis.”⁵ (It subsequently began expanding the list, which has grown to 19 states.) The AMA claimed that “runaway” juries and “skyrocketing” verdicts in these original 12 states were driving up malpractice insurance premiums. But when the AMA’s flagship publication, the *Journal of the American Medical Association (JAMA)*, published rankings of states’ quality of health care in January 2003, the truth became apparent. Georgia and eight other so-called “crisis states” ranked at the bottom in quality of care.⁶ [See Figure 4]

- **The real “crisis” is the quality of medical care.** According to *JAMA*, the quality of care in nine of the AMA’s original 12 “crisis states” ranks them in the bottom 20 states nationally. And five of the states rank among the bottom 10 states nationally: Florida 41st, New Jersey 43rd, Georgia 47th, Texas 49th, and Mississippi 50th.

Figure 4

Rankings of AMA’s Original “Crisis” States for Quality of Care, 2000-2001 and 1998-1999

State	JAMA Rank 2000-01	JAMA Rank 1998-99
Mississippi	50	51
Texas	49	45
Georgia	47	48
New Jersey	43	41
Florida	41	40
Ohio	38	33
Nevada	36	35
West Virginia	34	43
Pennsylvania	31	16
New York	24	30
Oregon	20	11
Washington	19	13

Source: Journal of the American Medical Association, January 2003.

Georgia Should Take the Lead in Funding a Patient Safety Program

In 1973, a blue ribbon commission appointed by the U.S. Department of Health, Education and Welfare (HEW) recommended that malpractice insurers dedicate a portion of each premium dollar to the study of malpractice incidents and creation of medical malpractice prevention programs. Public Citizen suggests that Georgia take this kind of action on the state level. The Legislature could take the lead in creating programs like the American Society of Anesthesiologists' Closed Claim Project. [See the next section of this report.] The effort cut in half the number of malpractice lawsuits filed against anesthesiologists and resulted in no increase in liability insurance premiums for this specialty between 1985 and 2002.

- **Small insurance surcharge could finance project to reduce medical errors.** Georgia could mandate a one-time 1 percent surcharge on malpractice insurance premiums to fund a Claims Analysis Project. As Georgia health care providers pay about \$200 million per year for insurance, such an assessment would yield \$2 million in seed money to start the program, perhaps at a medical school in Georgia. A 0.5 percent surcharge each year thereafter could provide operating expenses. If other states, perhaps working through the National Association of Insurance Commissioners, also assessed a dedicated Claims Analysis Project amount on their health providers' insurance premiums, insurers could then act collectively to create a national organization modeled on the Insurance Institute for Highway Safety. Eventually, medical specialties might opt out and direct their members' portion to a program operated by their specialty society.

In any event, claims analysis could be conducted and standards voluntarily adopted to reduce the incidence of medical malpractice. The result would be a win-win for patients and physicians – safer medical care and the lower premiums that it will bring.

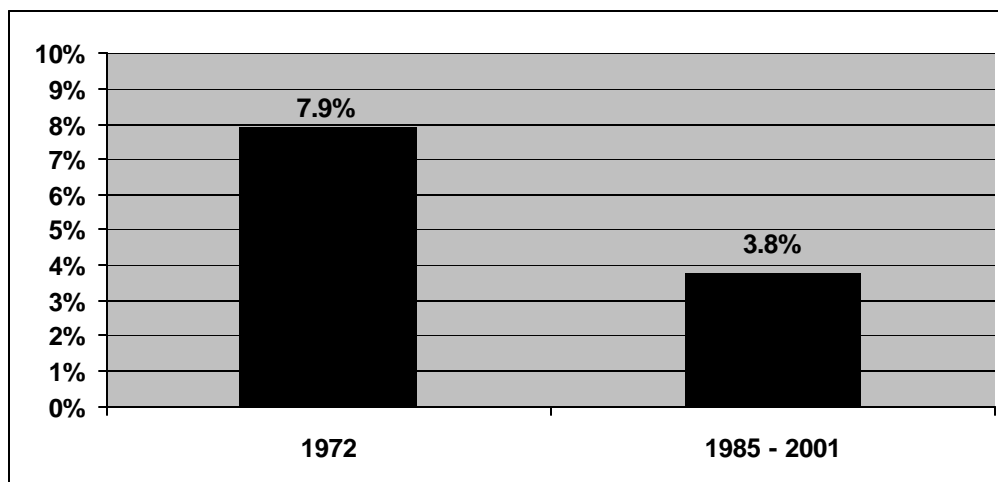
Anesthesiologists' Experience Shows Patient Safety Efforts Do More than Damage Caps to Reduce Lawsuits and Insurance Premiums

Generally speaking, doctors and their political organizations have resisted courts' findings of negligent medical care, choosing to fight the system rather than learn from mistakes. But an exception was the American Society of Anesthesiologists (ASA), which in 1985 initiated an effort to study malpractice claims. ASA established a Closed Claims Project at the University of Washington Medical School and gathered 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. [See Figure 5]
- In the 1970s, 64 percent of anesthesiology claims involved permanent disability or death; by the 1990s, only 41 percent did. [See Figure 6]
- The percent of anesthesia claims resulting in payments to plaintiffs dropped from 64 percent in the 1970s to 45 percent in the 1990s. [See Figure 7]

Figure 5

Percent of Malpractice Claims Involving Anesthesiologists

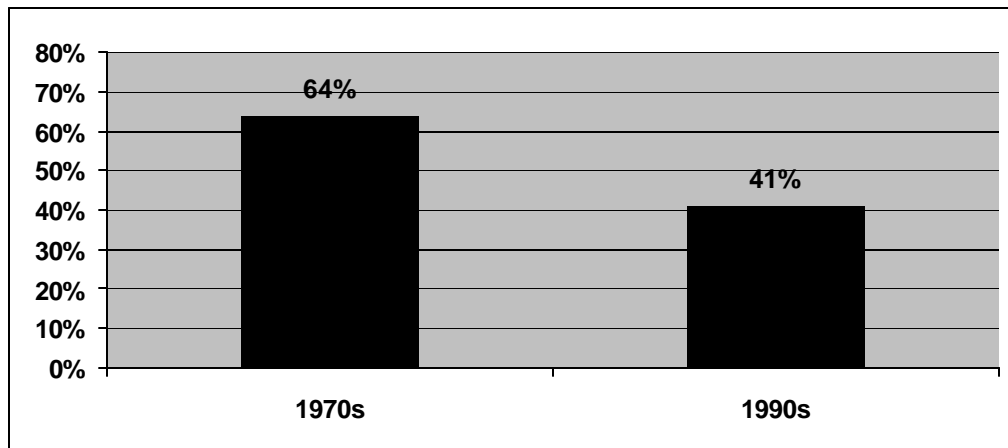


Sources: U.S. Department of Health, Education and Welfare, Secretary's Commission on Medical Malpractice, 1973; Physician Insurers Association of America, Cumulative Data Sharing Report, January 1, 1985 – December 31, 2001.

- 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). [See Figure 8]
- The safety effort proved far superior to damage caps in holding down awards. For example, during the 1990s, the median malpractice award in California, home to the most stringent cap on non-economic damages, increased by 103 percent; the median anesthesiology malpractice award remained constant. [See Figure 9]

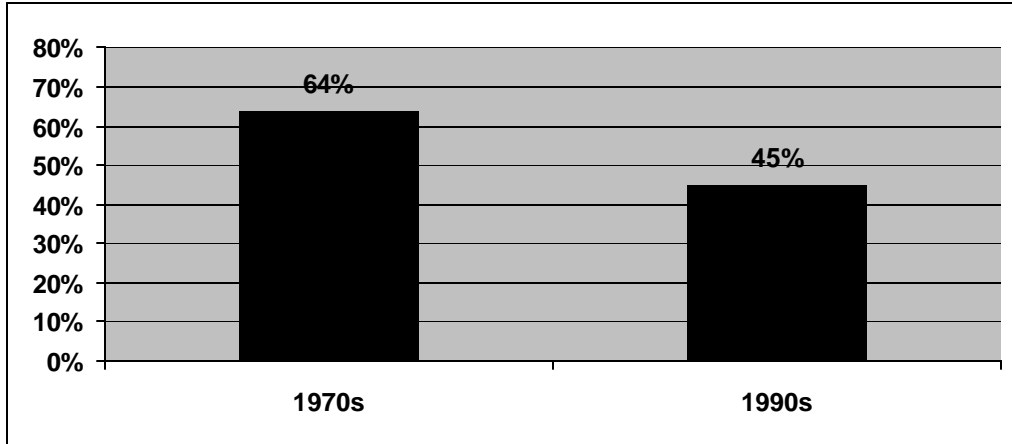
Figure 6

**Anesthesia Claims Involving Permanent Disability or Death,
1970s and 1990s**



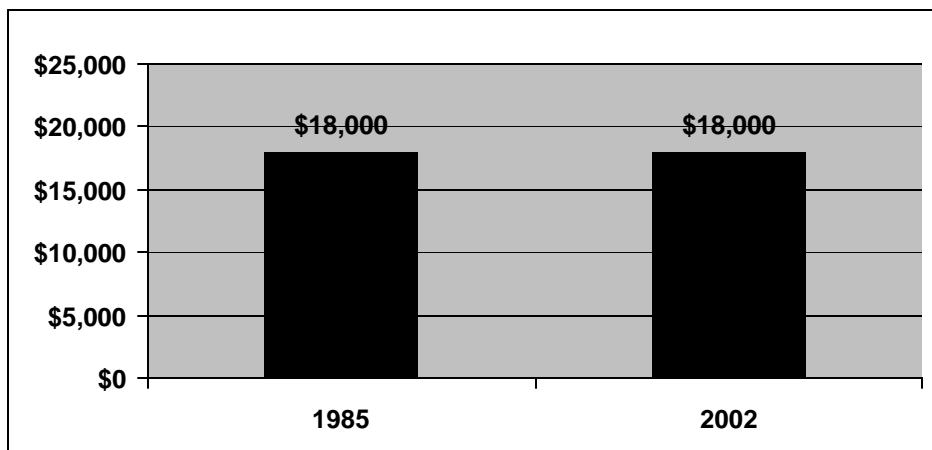
Source: American Society of Anesthesiologists, "Closed Claims Project Shows Safety Evolution," 2001.

Figure 7
Percent of Anesthesia Claims Closed with Payment, 1970s and 1990s



Source: American Society of Anesthesiologists, "Closed Claims Project Shows Safety Evolution," 2001.

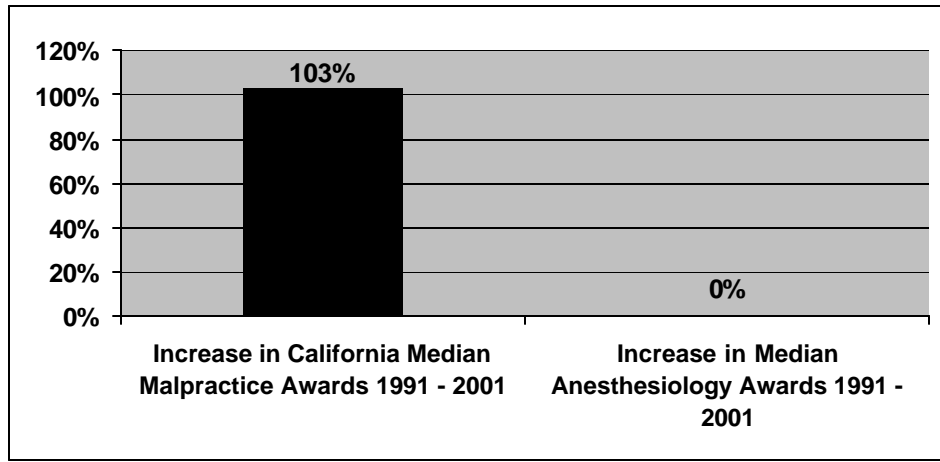
Figure 8
Average Premium for Anesthesiologists, 1985 and 2002



Source: American Society of Anesthesiologists, "Another Malpractice Insurance Crisis Brewing for Anesthesiologists?" June 2002.

Figure 9

Effectiveness of Caps vs. Patient Safety in Reducing Awards



Sources: National Practitioner Data Bank, 2001 Annual Report; American Society of Anesthesiologists, "Closed Claims Project Shows Safety Evolution," 2001.

Survey of Georgia Doctors Reporting that They Will Discontinue Their Practices Is Unreliable

In Georgia and other so-called “malpractice crisis” states, proponents of limiting patients’ rights to recover damages for medical malpractice frequently rely upon surveys of physicians that purport to prove that the supply of physicians and access to medical care have been adversely affected by rising malpractice premiums. The Medical Association of Georgia (MAG) contends that patients in Georgia face a “real crisis” with regard to physician supply and access to medical care. Unfortunately, the most current information about overall physician supply trends in Georgia is from the year 2000, which is before the “crisis” began.

Claims by state medical associations led the U.S. General Accounting Office (GAO), the non-partisan congressional watchdog, to perform a detailed examination in five of the AMA’s “crisis” states to determine whether evidence supported the claim of state medical associations and other provider groups that rising malpractice premiums affected consumers’ access to health care.

Below is a two-page summary of the GAO’s findings. It is followed by Public Citizen’s analysis of two surveys of Georgia physicians, which form the basis of current claims that there is a crisis, but which we believe are heavily biased.

- **The GAO found that many of the reported provider actions were not substantiated or did not affect access to health care on a widespread basis.** The GAO study of August 2003 examined in depth five states on the AMA’s crisis list: Florida, Mississippi, Nevada, Pennsylvania and West Virginia. The study failed to reveal convincing evidence that increased malpractice insurance premium costs had caused a significant number of physicians to move, retire or reduce high-risk services.⁷
 - The GAO report said: “In the five states with reported problems ... *we determined that many of the reported provider actions taken in response to malpractice pressures were not substantiated or did not widely affect access to health care.* For example, some reports of physicians relocating to other states, retiring, or closing practices were not accurate or involved relatively few physicians.”⁸ (emphasis supplied)
 - Although the GAO confirmed instances in which “actions taken by physicians [in response to malpractice insurance rates] have reduced access to services ... these were not concentrated in any one geographic area and often occurred in rural locations, where maintaining an adequate number of physicians may have been a long standing problem.”⁹ The GAO further reported that “the problems we confirmed were limited to scattered, often rural, locations and in most cases providers identified long-standing factors in addition to malpractice pressures that affected the availability of services.”¹⁰
 - The volume of medical care delivered to patients in the five crisis states had *increased* during the so-called crisis period.¹¹

- GAO’s analysis of utilization rates among Medicare beneficiaries for three of the specific services frequently cited as being reduced – spinal surgery, joint revisions and repairs and mammography – did not identify recent reductions.¹²
- Job actions by the AMA, its state affiliates, and member doctors to protest rising insurance rates limited the access of their patients to certain medical services. Specifically, the GAO found that in Nevada, “To draw attention to their concerns about rising medical malpractice premiums, over 60 orthopedic surgeons in [Clark] County withdrew their contracts with the University of Nevada Medical Center, causing the state’s only Level I trauma center to close for 11 days in July 2002.” And, in Florida, “at least 19 general surgeons who serve [Jacksonville’s] hospitals took leaves of absence beginning in May 2003 when state legislation capping non-economic damages for malpractice cases at \$250,000 was not passed.”¹³
- AMA “surveys” of doctors were not reliable. “Survey data used [by AMA] to identify service cutbacks in response to physician concerns about malpractice pressures are not likely representative of the actions taken by all physicians. ... AMA recently reported that about 24 percent of physicians in high-risk specialties responding to a national survey have stopped providing certain services; however, the response rate for this survey was low (10 percent overall), and AMA did not identify the number of responses associated with any particular service.”¹⁴
- In response to questions by the AMA regarding the application of its findings to states other than the five crisis states studied, the GAO said: “While we did not attempt to generalize our findings beyond these five states, we believe that – because they are among the most visible and often-cited examples of ‘crisis’ states – the experiences of these five states provide important insight into the overall problem.”¹⁵

Regarding three of the specific states covered in its study, the GAO reported:

- In Florida, where doctors’ successfully lobbied for the passage of a cap on damages, “[r]eports of physician departures ... were anecdotal, not extensive, and in some cases ... inaccurate. For example, state medical society officials told us that Collier and Lee counties lost all of their neurosurgeons due to malpractice concerns; however, we found at least five neurosurgeons currently practicing in each county as of April 2003. ... [O]ver the past two years the number of new medical licenses issued has increased and physicians per capita has remained unchanged.”¹⁶
- “In Nevada, 34 OB/GYNs reported leaving, closing practices, or retiring due to malpractice concerns; however, confirmatory surveys conducted by the Nevada State Board of Medical Examiners found nearly one-third of these reports were inaccurate. ... Random calls [GAO] made to 30 OB/GYN practices in Clark County found that 28 were accepting new patients. ... Similarly, of the 11 surgeons reported to have moved or discontinued practicing, the board found four were still practicing.”¹⁷

- “In Pennsylvania, despite reports of physician departures, the number of physicians per capita in the state has increased slightly during the past six years. The Pennsylvania Medical Society reported that between 2002 and 2003, 24 OB/GYNs left the state due to malpractice concerns; however, the state’s population of women age 18 to 40 fell by 18,000 during the same time period.”¹⁸
- **Biased surveys of Georgia physicians failed to produce objective or reliable information concerning physician supply or access to medical care.** MAG, like the medical societies in states studied by GAO, relies largely on the results of two physician surveys to justify its contention that the cost of malpractice insurance is threatening the availability of health care providers. The first survey was conducted by the Georgia Board for Physician Workforce (GBPW) in January 2003,¹⁹ and the second was a similar survey by the Georgia Obstetrical and Gynecological Society in fall of 2003.²⁰ Both agencies are totally controlled by physicians. In fact, GBPW is chaired by a doctor who sits on the Executive Committee of the doctors’ political organization and on the Board of Directors of the largest medical malpractice insurance company in Georgia – two groups leading the lobbying effort for tort law changes in Georgia.
- **Survey bias:** According to the surveys, physicians answered questions about whether they had stopped or planned to stop providing certain high-risk procedures as a result of the cost of malpractice insurance. Specifically, they were asked these questions about providing emergency room coverage, mammography and delivering babies. The questions were invariably presented in a leading, suggestive style designed to achieve a certain result: “Have you stopped or do you plan to stop providing _____ *as a result of the cost of malpractice insurance?*”²¹(emphasis added)
- Results obtained from these surveys should be approached with caution. Asking the question, “Have you stopped or do you plan to stop providing certain high-risk procedures as a result of the cost of malpractice insurance?” is leading and clearly indicates the desired answer. This phrasing of the question does not distinguish between situations in which physicians limit certain practices or procedures for reasons other than malpractice, such as age, health, lateral moves, lifestyle or a desire to move to other, more attractive locations.

For instance, as the *New York Times* reported on Feb. 3, 2004, many surgeons have moved from full-service hospitals to lucrative, doctor-owned specialty hospitals that do not provide emergency care. On Dec. 27, 2003, Dr. Jacqueline W. Fincher of Thomson, Ga. told the *Augusta Chronicle* that there was a shortage in the “high-risk area” of radiology.²² Yet on Jan. 7, 2004, the *New York Times* reported that medical students are choosing emergency medicine and radiology as their specialties in record numbers, citing lifestyle considerations. According to a *JAMA* study reported in the article, “Lifestyle considerations accounted for 55 percent of a doctor’s choice of specialty in 2002.”²³

Had the questions been presented in two parts, “Have you changed your practice?” and, “If so, why?” they would have been more likely to separate malpractice from

non-malpractice reasons. Had the surveys accounted for new entrants to the medical profession, the reported losses may have been offset. Unfortunately, the two studies relied upon by MAG used only leading questions designed to produce desired responses.

Asking a physician whether he plans to limit his practice on account of the high cost of medical liability insurance is the substantial equivalent of asking a prison inmate requesting early release if he will be good once he is set free. The response is a foregone conclusion.

- **Examining claims that obstetricians will limit procedures:** One of the survey findings highlighted by MAG is the claim that many obstetricians plan to stop providing high-risk procedures and will no longer deliver babies because of rising insurance rates. Unfortunately, the report provides no context or perspective for this claim, which is contradicted by a recent, authoritative study, which found no relationship between the level of increase in liability insurance premiums and the likelihood of discontinuing obstetric practice. That 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 were. (The AMA also has identified New York as a “crisis” state.) It 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.”²⁴
- **Number of OB/GYNs in Georgia:** The number of Georgia OB/GYNs per 100,000 population did not change significantly from 1990 through 2000, the latest year for which the Georgia Board for Physician Workforce has reported statistics.²⁵ Moreover, the two surveys give no numbers for the new obstetricians licensed in the state each year or the numbers that normally leave or retire from practice each year. Obstetricians frequently cut back on their practice as they advance in years and become financially secure. As the child-bearing years of their patient population pass, some obstetricians give up the demands of delivering babies in favor of concentrating on the gynecological needs of their patients. For example, in 2000, 18.7 percent of Georgia’s OB/GYNs were between 40 and 44 years old, but only 11.1 percent of OB/GYNs were 50-54 years old – a decrease of about 40 percent.²⁶

California's Lower Malpractice Insurance Premiums Are Due to Insurance Reforms Not Damage Caps

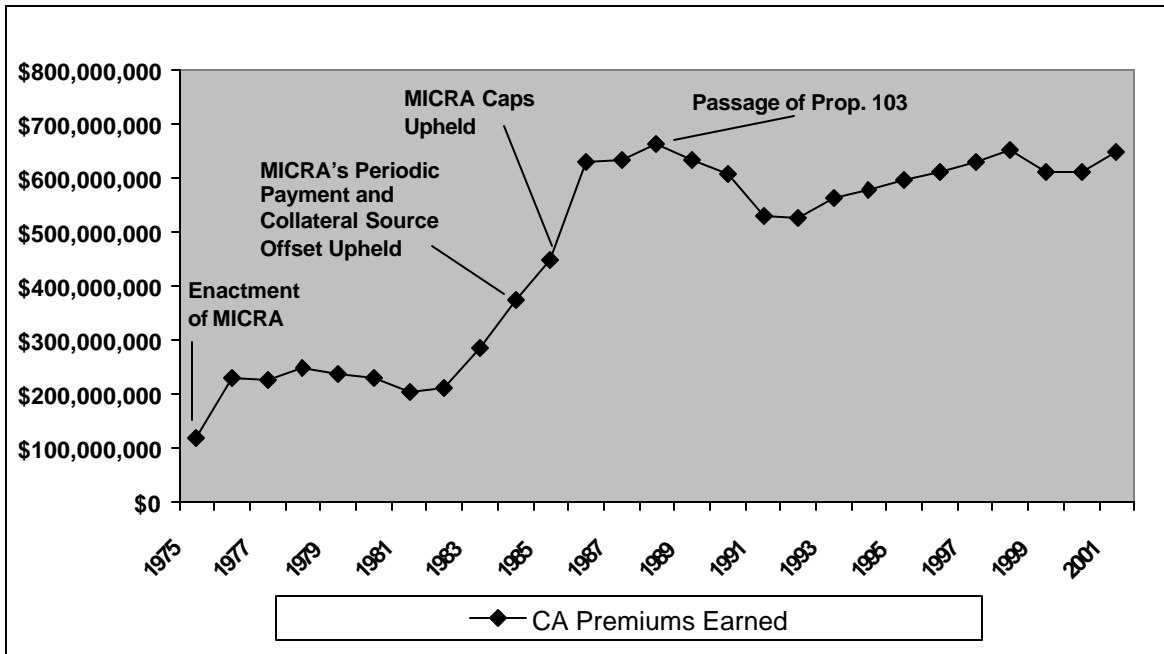
The experience with medical malpractice insurance rates in California is heavily promoted by doctors and insurance companies as justification for caps on non-economic damages. In 1975 California passed MICRA (Medical Injury Compensation Reform Act), the centerpiece of which is a \$250,000 cap on non-economic damages (which does not even allow for inflation increases). Ever since, this has been the model law for efforts to restrict patients' legal rights in other states.

Ironically, the California experience exemplifies the success of insurance reforms, not the imposition of damage caps, at keeping malpractice rates lower. In a revolt against skyrocketing auto and homeowners insurance rates, voters passed Proposition 103 in 1988. This strong pro-consumer measure, which also applied to lines of medical malpractice insurance, instituted a 20 percent rate rollback and made it much more difficult for companies to get future rate increases.

The effect on medical-malpractice insurance premiums was staggering. In the first 12 years of MICRA (1976-1988) malpractice insurance premiums earned (paid) *increased* 190 percent, but under Prop 103 premiums earned *declined* 2 percent from 1988-2001.²⁷ [See Figure 10]

- **California premiums continued to rise after enactment of MICRA.** In 1976, the first year of MICRA, the total premiums earned by California insurers were \$228.5 million but by 1988 premiums had skyrocketed to \$663.2 million – a jump of 190 percent. Initially insurers argued that questions concerning the constitutionality of MICRA prevented the lowering of premiums. However, MICRA's constitutionality was upheld in State Supreme Court decisions handed down in 1984 (periodic payments and collateral source provisions upheld) and 1985 (damage cap upheld). Nevertheless, premiums earned saw their largest jump in 1986 than in any year since the adoption of MICRA despite the fact that insurance companies set premiums based on *what they expect that years' losses to be in the future*, not based on what happened in the past.
- **Medical malpractice premiums decreased after passage of Prop 103 in 1988.** In 1988, California voters, facing skyrocketing insurance premiums and angry at the failure of "tort reform" to deliver on its promise to reduce insurance rates, went to the ballot box and passed Prop 103 the nation's most stringent reform of the insurance industry's rates and practices. It was applicable to all lines of property-casualty insurance, including auto, homeowners, commercial and medical malpractice. Within three years of passage of Prop 103, medical malpractice premiums dropped 20 percent, and thereafter have generally followed the rate of inflation. Overall, since 1988 total premiums earned have decreased about 2 percent, dropping from \$663.2 million in 1988 to \$647.2 million in 2001.

Figure 10
California Medical Malpractice Premiums, 1975 - 2001



Source: The Foundation for Taxpayer and Consumer Rights, based on National Association of Insurance Commissioners' Reports on Profitability By Line By State, 1976-2001, Direct Premium Earned 1975. A.M. Best special data request.

- **Reasons Prop 103 has been so successful at reducing rates:**

- **Prop 103 created a stringent disclosure and “prior approval” system of insurance regulation.** This requires insurance companies to submit applications for rate changes to the California Department of Insurance for review before they are approved. Prop 103 gives the California Insurance Commissioner the authority to place limits on an insurance company’s profits, expenses and projections of future losses (a critical area of abuse).
- **Prop 103 repealed anti-competitive laws in order to stimulate competition and establish a free market for insurance.** Prop 103 repealed the industry’s exemption from state antitrust laws, and prohibited anti-competitive insurance industry “ration organizations” from sharing price and marketing data among companies, and from projecting “advisory,” or future, rates, generic expenses and profits. It repealed the law that prohibited insurance agents/brokers from cutting their own commissions in order to give premium discounts to consumers. It permits banks and other financial institutions to offer insurance policies. And it authorizes individuals, clubs and other associations to unite to negotiate lower-cost group insurance policies.

- Recent Consumer Challenge to Medical Malpractice Insurance Rate Hike Saves California Doctors \$23 Million.** California’s State Insurance Commissioner ruled in September 2003 that the second largest medical malpractice insurer’s rate request was excessive. The request was determined to be in violation of Prop 103 regulations. The Insurance Commissioner ordered medical malpractice insurer, SCPIE Indemnity, to slash its proposed rate increase for doctors by 36 percent after an eight-month regulatory investigation of the firm’s rate request. The Foundation for Taxpayer and Consumer Rights (FTCR), a California nonprofit, non-partisan organization that initiated the rate challenge called the ruling another tribute to the effectiveness of California’s insurance reform initiative known as Prop 103.
- Premiums for California doctors are not always lower even though damage awards are lower.** Proponents of restricting patients’ legal rights often like to compare medical malpractice insurance rates in their state with those in California. This is often difficult to do because the same insurer does not operate in both states. One company does operate in both California and Georgia for which Public Citizen was able to get rate information – the Doctors Company. Because a relatively small portion of premiums collected is paid out in compensation to patients, and a large portion pays for overhead and defense lawyer costs, California’s reduction in damage awards through the \$250,000 non-economic damages cap does not translate into reduced premiums. Comparing the rates for OB/GYNs in the states’ biggest urban area, the rates were 17 percent lower in Fulton County than in Los Angeles County and the rate increase in 2003 was the same.

Figure 11

**The Doctors Company
OB/GYN Premiums in 2003**

County	Premium	% Increase in 2003
Los Angeles, CA	\$60,259	10%
Fulton, GA	\$50,707	10%

Source: Medical Liability Monitor, 2003 Rate Report

Caps on Damages Are a False “Solution”

Doctors and their lobbyists in Georgia are pushing for a \$250,000 limit on non-economic damages, also known as “pain-and-suffering,” in medical malpractice cases. Such a cap, widely promoted by medical associations and their political allies, has not been proven to effectively lower medical malpractice insurance costs. It does, however, penalize the most severely injured patients while reducing physician, hospital and HMO accountability, thereby lessening deterrence against errors and negligence.

- **“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, 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.
- **A cap on non-economic damages effects only the most seriously injured patients.** A cap on non-economic damages is cruel and unusual punishment, because it affects only those who are most catastrophically harmed. According to Physician Insurers Association of America (PIAA), the average total payment between 1985 and 2001 for a “grave injury,” which encompasses paralysis, was only \$454,454. This includes both economic damages (health care costs and lost wages) and non-economic damages. Since about one-third to one-half of a total award comprises non-economic damages, a \$250,000 cap affects only patients with “grave injuries.”²⁸
- **Capping awards hurts children, women, seniors and minorities in particular.** Limiting medical malpractice awards for non-economic injury has a disproportionate impact on children, women and minorities. Children have no employment income, which is the basis for calculating most economic awards. One of the more significant medical injuries inflicted on women is harm to reproductive capacity, but that does not impact a woman’s earning capacity, and thus does not entitle her to economic damages despite the devastating emotional impact of such a loss. Retired seniors who suffer often deplorable neglect and abuse in nursing homes and other long-term care facilities have no employment income. Capping awards also discriminates against minorities since they have lower incomes on average than whites. In some cases, low wage earners are denied the opportunity to earn more in the future due to injuries caused by medical negligence.
- **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.²⁹ 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 criticism that jury verdicts are frequently unpredictable and irrational.

- **The insurance industry's own statistics demonstrate that awards are proportionate to injuries.** The PIAA Data Sharing Report also demonstrates the relationship between the severity of an injury and the size of the settlement or verdict.³⁰ PIAA, as do most researchers, measures severity of injury according to the National Association of Insurance Commissioners' classifications.³¹ 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.³²

Medical Liability Premium Spike Is Caused by the Insurance Cycle and Mismanagement, Not the Legal System

Although the AMA and state medical groups adamantly insist that patient litigation has triggered a medical malpractice insurance “crisis,” government agencies and experts in the insurance field attribute rises in the cost of malpractice insurance to a decade of under-pricing by carriers and a downturn in the U.S. economy since 2000.

- **Congressional Budget Office links rising premiums to insurance company investment losses.** In January 2004, the Congressional Budget Office 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.³³
- **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, has analyzed the recent growth in medical liability premiums.³⁴ 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.
- **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.”³⁵
- **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 (soft market). Following a period of solid but not spectacular rates of return, the industry enters a down phase (hard market) 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.³⁶

- **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.”³⁷ 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.”³⁸
- **West Virginia Insurance Commissioner blames the market.** According to the Office of the West Virginia Insurance Commission (one of the states battered by a so-called medical malpractice “crisis” in 2002 and 2003), “[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.”³⁹
- **Missouri Insurance Director says “tort reform” won’t relieve financial pressure on doctors.** In a February 2003 report on medical malpractice insurance, the director of Missouri’s Department of Insurance concluded that “further ‘tort reforms’ will not provide relief to financially distressed physicians for several years, if at all.” His report also found that “[p]hysicians are hard-pressed to absorb increased malpractice insurance costs when they have limited ability to pass on those expenses to managed care companies and government programs.”⁴⁰

- **Leading financial analyst recognizes the true cause of premium spikes.** Weiss Ratings, the “leading independent provider of ratings and analyses of financial services companies, mutual funds, and stocks,” 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.”⁴¹ According to Weiss, six factors driving increases in medical malpractice rates are:
 - **Medical cost inflation.** Medical costs have risen 75 percent since 1991.
 - **The cyclical nature of the insurance market.** In an attempt to catch up, insurers have tightened underwriting standards and raised premiums.
 - **The need to shore up reserves for policies in force.** The only way to shore up reserves is to increase premiums.
 - **A decline in investment income:** This is particularly critical for lines of business like medical malpractice, in which the duration of claims payouts typically spans several years.
 - **Financial safety:** To restore their financial health, many medical malpractice insurers will remain under pressure to increase rates.
 - **The supply and demand for coverage:** The number of medical malpractice carriers increased nationally through 1997 to 274, but has since fallen to 247 in 2002.
- **The American Medical Association acknowledges that spikes in malpractice premiums are caused by insurance cycles.** In a report by the AMA’s Board of Trustees to its House of Delegates, the following statements acknowledged that increasing malpractice insurance premiums were linked to the insurance underwriting cycle:

“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.”⁴²

“For several years, insurers kept prices artificially low while competing for market share and new revenue to invest in a booming stock market. As the bull market surged, investments by these historically conservative insurers rose to 10.6 percent in 1999, up from a more typical 3 percent in 1992. With the market now in a slump, the insurers can no longer use investment gains to subsidize low rates. The industry reported realized capital gains of \$381 million last year, down 30 percent from the high point in 1998, according to the A.M. Best Company, one of the most comprehensive sources of insurance industry data.”⁴³

Insurance Companies and Their Lobbyists Admit It: Caps on Damages Won't Lower Insurance Premiums

Caps on damages for pain and suffering will significantly lower the awards paid to catastrophically injured patients. But because such truly severe cases make up a small percentage of medical malpractice claims, and because the portion of the medical liability premium dollar that pays for compensation is dwarfed by the portion that pays for defense lawyer fees, caps do not lead to lower premiums. Insurance companies and their lobbyists understand this – so don't take our word for it, take theirs.

Premium on the Truth:

“Insurers never promised that tort reform would achieve specific savings.” – American Insurance Association⁴⁴

“We wouldn't tell you or anyone that the reason to pass tort reform would be to reduce insurance rates.” – Sherman Joyce, president of the American Tort Reform Association⁴⁵

“Many tort reform advocates do not contend that restricting litigation will lower insurance rates, and I've never said that in 30 years.” – Victor Schwartz, general counsel to the American Tort Reform Association⁴⁶

“There doesn't seem to be a lot of evidence that supports a correlation between caps and premiums.” – Leo Jordan, retired vice president and counsel for State Farm Insurance Companies⁴⁷

California

“I don't like to hear insurance-company executives say it's the tort [injury-law] system – it's self-inflicted,” – Donald J. Zuk, chief executive of Scpie Holdings Inc., a leading malpractice insurer in California⁴⁸

Florida

“No responsible insurer can cut its rates after a bill (that caps damages at \$250,000) passes.” – Bob White, president of First Professionals Insurance Co. (formerly Florida Physicians Insurance Company, Inc). The company is the largest medical malpractice insurer in Florida and has close ties to the Florida Medical Association.⁴⁹

Mississippi

“Regardless of what may result from the ongoing tort reform debate, please remember that such proposed public policy changes are critical for the long-term, but do not provide a magical 'silver-bullet' that will immediately affect medical malpractice insurance rates ... The 2003 rate change [a 45 percent increase] would happen regardless of the special session outcome.” – Medical Assurance Company of Mississippi⁵⁰

Nevada

“The primary insurer for Las Vegas obstetricians, American Physicians Assurance, has no plans to lower premiums for several years, if ever, said broker Dennis Coffin.” – Coffin is the Account Representative for SCW Agency Group – Nevada, which represents the American Physicians Assurance Corp.⁵¹

“[John Cotton of the Nevada Physicians’ Task Force] noted that even if the bill reflected a cap of \$5, there would not be an immediate impact on premiums.” – Minutes of the Nevada Assembly Committee on Medical Malpractice Issues⁵²

New Jersey

During a hearing on medical malpractice issues, New Jersey Assemblyman Paul D’Amato asked Patricia Costante, Chairwoman and CEO of MIIX Group of Companies, “[A]re you telling the insured physicians in New Jersey that if this State Legislature passes caps that you’ll guarantee that you won’t raise your premiums, in fact, you’ll reduce them?” Costante replied: “No, I’m not telling you [or them] that.”⁵³

Financial analysis shows malpractice award “caps” would have little impact on the premiums doctors pay. In an analysis requested by the Medical Society of New Jersey, actuaries estimate that a “cap” on non-economic damages in malpractice cases would have only a slight impact on the amount doctors pay in liability premiums. “We would expect a \$250,000 cap on non-economic damages would produce some savings, perhaps in the 5 percent to 7 percent range,” the firm of Tillinghast-Towers Perrin reports. “A cap of \$500,000 is likely to be of very little benefit to physicians.”⁵⁴

Ohio

“In the short run, we may even see prices go up another 20 percent, and people will say, ‘Gee, what happened, I thought we addressed this?’” – Ray Mazzotta, president of Columbus-based Ohio Hospital Insurance Co.⁵⁵

“The stroke of the governor’s pen [enacting caps on damages] will not result in immediate lowering of rates by responsible companies.” – Frank O’Neil, spokesman for Birmingham, Ala.-based Medical Assurance⁵⁶

Wyoming

During a hearing on medical malpractice insurance issues, Bruce Crile of the Doctors’ Company and Melissa Dennison of OHIC Insurance Company testified that insurance rates would not drop if caps on damages were imposed. “Both the Doctors’ Company and OHIC’s actuaries say a cap of \$500,000 is meaningless for purposes of ratemaking. Even with caps enacted premiums will still increase, but with predictability of the risk there will be a moderating of rate increases.” – Minutes of the Wyoming Legislature’s Joint Labor, Health and Social Services Interim Committee⁵⁷

Endnotes

¹ National medical malpractice insurance costs of \$9.6 billion based on “Medical Malpractice Insurance – A Study of Market Conditions,” table 13, “2002 Medical Liability Profitability Results By State,” Property and Casualty Committee, National Association of Insurance Commissioners, Dec. 3, 2003. National health care costs for 2002 of \$1.55 trillion as reported by representatives of the National Health Statistics Group, Office of the Actuary, Centers for Medicare and Medicaid Services, “Health Spending Rebound Continues in 2002,” *Health Affairs*, Vol. 23, No. 1, 2003.

² *To Err Is Human, Building a Safer Health System*, Institute of Medicine, 2000, p. 26-27.

³ “Medical Malpractice Insurance – A Study of Market Conditions,” table 13, “2002 Medical Liability Profitability Results By State,” Property and Casualty Committee, National Association of Insurance Commissioners, Dec. 3, 2003.

⁴ National Practitioner Data Bank, Sept. 1, 1990 – Sept. 30, 2003.

⁵ “AMA Announces Wyoming as 19th Medical Liability Crisis State,” statement from the American Medical Association, July 9, 2003. Available at <http://www.ama-assn.org/ama/pub/article/9255-7865.html>.

⁶ Stephen F. Jencks, Edwin D. Huff, Timothy Cuedon, “Change in the Quality of Care Delivered to Medicare Beneficiaries, 1998-1999 to 2000-2001,” *Journal of the American Medical Association*, Jan. 15, 2003.

⁷ United States General Accounting Office, “Medical Malpractice: Implications of Rising Premiums on Access to Health Care,” GAO-03-836, August 2003. Available at <http://www.gao.gov/new.items/d03836.pdf>.

⁸ GAO Study at p. 5.

⁹ GAO Study at p. 5.

¹⁰ GAO Study at p. 13.

¹¹ GAO Study at p. 20.

¹² GAO Study at p. 20.

¹³ GAO Study at p. 13-14.

¹⁴ GAO Study at p. 20.

¹⁵ GAO Study at p. 7.

¹⁶ GAO Study at p. 17.

¹⁷ GAO Study at p. 18.

¹⁸ GAO Study at p. 18.

¹⁹ Georgia Board for Physician Workforce, “Effect of the Medical Liability Crisis on Physician Supply and Access to Medical Care in Georgia,” January 2003.

²⁰ “Statewide Survey of Members,” Georgia Obstetrical and Gynecological Society, 2003.

²¹ The surveys included the following questions: Have you stopped or do you plan to stop providing certain high-risk procedures as a result of the cost of malpractice insurance? Have you stopped or do you plan to stop providing emergency room coverage as a result of the cost of malpractice insurance? Do you plan to leave clinical practice during the next year as a result of the cost of malpractice insurance? Do you plan to leave the state within the next year as a result of the cost of malpractice insurance?

²² Jacqueline W. Fincher, “Malpractice Litigation Lottery for Lawyers,” *Augusta Chronicle*, Dec. 27, 2003.

²³ “The Shifting Burden of Emergency Care,” *New York Times*, Feb. 3, 2004.

²⁴ 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.

²⁵ Georgia Board for Physician Workforce, “Physician Workforce 2000 Report,” August 2001.

²⁶ Georgia Board for Physician Workforce Report at p. 7.

²⁷ All of the information in this section analyzing MICRA and Prop 103 is taken from the testimony of Harvey Rosenfield, President, The Foundation for Taxpayer and Consumer Rights, before the U.S. House Energy and Commerce Committee, Subcommittee on Health, February 27, 2003.

²⁸ Frank A. Sloan, Penny Githens, Ellen Clayton, Gerald Hickson, Douglas Gentile and David Partlett, “Suing For Medical Malpractice,” *University of Chicago Press*, 1993.

²⁹ Kelso & Kelso, *Jury Verdicts in Medical Malpractice Cases and the MICRA Cap*, Institute for Legislative Practice (1999). N. Vidmar, F. Gross, M. Rose, “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).

³⁰ *PIAA Data Sharing Report*, Report 7, Part 10.

³¹ 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

³² N. Vidmar, F. Gross, M. Rose, "Jury Awards for Medical Malpractice and Post-Verdict Adjustments of Those Awards," 48 *DePaul Law Review* 265, 1998.

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³⁴ Americans for Insurance Reform, "Medical Malpractice Insurance: Stable Losses/Unstable Rates," Oct. 10, 2002. See also: <http://www.insurance-reform.org/StableLosses.pdf>.

³⁵ Charles Kolodkin, "Medical Malpractice Insurance Trends? Chaos!" International Risk Management Institute. <http://www.irmi.com/expert/articles/kolodkin001.asp>

³⁶ "Hot Topics & Insurance Issues," Insurance Information Institute, www.iii.org

³⁷ Christopher Oster and Rachel Zimmerman, "Insurers' Missteps Helped Provoke Malpractice 'Crisis,'" *Wall Street Journal*, June 24, 2002.

³⁸ Charles Kolodkin, Gallagher Healthcare Insurance Services, "Medical Malpractice Insurance Trends? Chaos!" September 200, available at <http://www.irmi.com/expert/articles/kolodkin001.asp>.

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⁴⁶ Michael Prince, "Tort Reforms Don't Cut Liability Rates, Study Says," *Business Insurance*, July 19, 1999

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⁴⁸ Rachel Zimmerman and Christopher Oster, "Assigning Liability: Insurers' Missteps Helped Provoke Malpractice 'Crisis'; Lawsuits Alone Didn't Cause Premiums to Skyrocket; Earlier Price War a Factor," *The Wall Street Journal*, June 24, 2002.

⁴⁹ Phil Galewitz, "Underwriter Gives Doctors Dose of Reality," *The Palm Beach Post*, January 29, 2003 and Mike Salinero, "Insurers Tied To Florida Doctors," *The Tampa Tribune*, March 22, 2003.

⁵⁰ Julie Goodman, "Premiums Rise by 45 Percent; Insurance Group's Hike Comes as Doctors Seek Relief," *Clarion-Ledger* (Jackson, Miss.), September 22, 2002.

⁵¹ Joelle Babula, "Obstetricians Say Problems Remain," *The Las Vegas Review-Journal*, October 1, 2002.

⁵² "Testimony on Assembly Bill 1: To Make Various Changes Related to Medical and Dental Malpractice," Nevada Assembly Committee on Medical Malpractice Issues, July 30, 2002.

⁵³ "Testimony Concerning the Affordability of Medical Malpractice Insurance for Physicians Practicing in New Jersey," Public Hearing Before the Assembly Health and Human Services Committee and Banking and Insurance Committee, June 3, 2002.

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⁵⁶ "No Drop in Malpractice Rates Pending," *The Associated Press*, January 10, 2003.

⁵⁷ Testimony at the Wyoming Legislature's Joint Labor, Health and Social Services Interim Committee, December 4-6, 2002.