The Facts About Medical Malpractice in Pennsylvania

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Acknowledgments

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- **The annual number of medical malpractice awards in Pennsylvania declined at least 6.3 percent and as much as 13.1 percent from 1995 to 2002.** According to the federal National Practitioner Data Bank (NPDB), there were 957 medical malpractice awards made in Pennsylvania in 1995, and 832 awards made in 2002 – a decrease of 125, or 13.1 percent. (If this number is adjusted by adding certain payments by the state supplemental fund (Mcare) to the total, the number of awards was 996 in 1995 and 933 in 2002 – still a decrease of 63 awards, or 6.3 percent.)

- **The rate of medical malpractice awards per Pennsylvania physician dropped at least 9.2 percent and as much as 16 percent from 1995 to 2002.** Based on the total number of awards reported by the NPDB, the number of malpractice awards per 100 Pennsylvania doctors was 2.81 in 1995 and dropped to 2.36 in 2002 – a decline of 16 percent. (If this ratio is based on the adjusted number of total awards, the rate of awards per 100 doctors dropped from 2.92 in 1995 to 2.65 in 2002 – a decrease of 9.2 percent.)

- **Mcare/CAT claims, cases and payouts have declined or been stable the past five years.** The number of claims on whose behalf Mcare/CAT, Pennsylvania's supplemental insurance fund, has made payouts declined from 706 in 1999 to 699 in 2003, according to the Pennsylvania Department of Insurance. The number of cases that Mcare has made payouts on has dropped from 580 in 1999 to 542 in 2003 over the same period – a decrease of 6.5 percent. The total amount of payouts for all claims rose by only 1 percent a year from 1999 to 2003, from $300.8 million to $314.0 million, after adjusting for medical care services inflation.

- **The number of million-dollar jury verdicts fell by 50 percent from 2000 to 2002.** The number of jury verdicts of $1 million or more declined from 44 in 2000 to 22 in 2002, according to the Pennsylvania Department of Insurance. And the overall amount of these awards decreased by over 75 percent, from $415 million to $93 million.

- **The number of medical malpractice cases filed in Philadelphia dropped 58 percent in 2003, as a result of procedural rules changes regarding venues mandated by the State Supreme Court.** In 2003, 572 medical malpractice cases were filed in Philadelphia, compared with 1,352 in 2002 – a 58 percent drop – according to the Common Pleas Court in Philadelphia. Moreover, by the end of 2003, at least 298 medical malpractice cases had been transferred out of Philadelphia to other counties – a 15.9 percent reduction of the court's medical malpractice inventory. The city is regularly used as the poster child by those claiming a constitutional amendment must be passed to limit damage

awards. Given the dramatic decrease in the city's case filings the pressure surely should be off for further restrictions to patients' legal rights.

- **The number of Pennsylvania doctors rose 5.6 percent from 1994 to 2002.** In 1994, 33,321 physicians paid into the state's Mcare Fund, run by the insurance department. In 2002, the last year for which data is available, the number of participating physicians had risen to 35,180 – an increase of 1,859, or 5.6 percent. In comparison, the state's overall population grew just 3.3 percent from 1990 to 2000.

- **The ratio of physicians per 1,000 Pennsylvania residents grew 37.2 percent from 1985 to 2001.** In comparison, during the same period this measurement increased at a slower rate in five neighboring states (Maryland, New Jersey, New York, Ohio, and Virginia), two of which had caps on malpractice damage awards in place.

- **Vital information about medical malpractice in Pennsylvania is lacking, which is reason enough for not proceeding with amending the state's constitution.** For example, there is no reliable data on the number of medical malpractice cases filed annually in the state, which is why the state Supreme Court recently ordered local courts to begin tracking such information. The only reliable information that exists about the number of Pennsylvania doctors in any given specialty is maintained by the American Medical Association, but it has refused to release this data during the debates on malpractice policy, choosing instead to rely on unsubstantiated anecdotes. Moreover, there is no reliable data on the portion of medical malpractice payouts that comprise economic and non-economic damages, and how each category has trended over time.

- **The General Accounting Office essentially found that the AMA and allied groups manufactured a "crisis" to push their agenda of changing medical malpractice laws.** The GAO compared conditions in five AMA-designated "crisis states," including Pennsylvania, 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.

- **Medical liability premium spikes are caused by the insurance cycle and mismanagement, not the legal system.** In December, 2003, 17 new entities were approved to offer medical malpractice insurance in Pennsylvania, according to the state insurance department's, illustrating the temporary nature of the "hard" market that drove some insurers to drastically raise rates or discontinue writing policies. The Congressional Budget Office recently noted that the country's 15 biggest medical malpractice insurers saw their investment returns drop by 1.6 percent from 2000 through 2002 – a figure that corresponds to almost half of the 15 percent increase in medical malpractice premium rates estimated by the U.S. government. Medical inflation, which is running at about 5 percent a year probably accounts for the rest of the increase.

- **Reduced fees – not insurance rates – are the biggest financial burden on doctors.** Doctors across the country have seen their fees slashed in recent years as managed

care companies tried to increase profits, and government programs, such as Medicare and Medicaid, tried to cut costs. The AMA estimates that since 1991 physician practice costs have risen by 35 percent, but Medicare payments have risen only 10 percent. That means practice costs have risen two-and-a-half times the rate of Medicare payments. The tort system is a convenient whipping boy for doctors who will continue to chafe from cost containment measures, but victims of medical negligence should not be made to compensate for declining reimbursement rates.

- **Medical malpractice premiums account for a very small share of a physician's practice revenue – ranging from 2.2 percent to 7.6 percent, according to *Medical Economics* magazine.**

- **A landmark Harvard Medical Practice study found that only a small percentage of medical errors result in lawsuits, letting doctors benefit from a claims gap.** Harvard researchers using a sample of hospitalizations in New York State compared medical records to claims files. They found that only one in 7.6 instances of medical negligence committed in hospitals results in a malpractice claim. Researchers replicating this study made similar findings in Colorado and Utah.

- **Expenditures on medical liability comprise less than 1 percent of overall health care costs.** As the Congressional Budget Office reported, "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."

- **The Congressional Budget Office has rejected the defensive medicine theory.** The Congressional Budget Office was asked to quantify the savings from reduced "defensive medicine" under draconian federal legislation that included a $250,000 non-economic damages cap. 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."

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

- **The real impact of medical malpractice in Pennsylvania should be measured by the cost to patients and consumers, not the premiums paid by health care providers.** Extrapolating from Institute of Medicine findings, we estimate that there are 1,920 to 4,277 hospital deaths in Pennsylvania each year due to preventable medical errors.

The costs resulting from preventable medical errors to Pennsylvania's residents, families and communities are estimated at $742 million to $1.3 billion each year. But the cost of medical malpractice insurance to Pennsylvania's health care providers is about $683 million a year.

- **5.3 percent of doctors nationally are responsible for 56 percent of medical malpractice payouts, according to the National Practitioner Data Bank.** Each of these doctors has made at least two medical malpractice payouts. Even more surprising, just 2 percent of all doctors, each of whom has paid three or more malpractice claims, were responsible for 30.9 percent of all payouts. Moreover, 83.2 percent of the nation's doctors have never made a malpractice payout.

- **Doctors with repeated malpractice claims against them suffer few consequences.** According to the NPDB, only 11.1 percent of the nation's doctors who made three or more malpractice payouts were disciplined by their state boards. Only 14.4 percent of the nation's doctors who made four or more malpractice payouts were disciplined by their state boards. Only 17.2 percent of the nation's doctors who made five or more malpractice payouts were disciplined by their state boards.

- **13 physicians in Pennsylvania have made between 4 and 15 malpractice payouts totaling more than $5 million per doctor, but have not been disciplined, according to the NPDB.** Collectively, these 18 physicians have been responsible for 94 medical malpractice payments to patients totaling $86 million.

- **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.

Section III: Caps on Damages Are Unjust and Offer No Solution to Rising Premiums

- **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.

- **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.

- **Damage caps don't guarantee lower malpractice insurance premiums.** A comparison of 2003 rates contained in the Medical Liability Monitor shows that internists, general surgeons and ob/gyns generally pay less in Philadelphia than their counterparts do in Detroit when insured by the same carrier or when comparing rates between the largest insurers in the marketplace. Pennsylvania has no cap and Detroit limits non-economic damages to $366,000 for non-catastrophic injuries and $635,500 for catastrophic injuries.

Section I

Lawsuits Are not Responsible for Rising Medical Malpractice Insurance Premiums in Pennsylvania

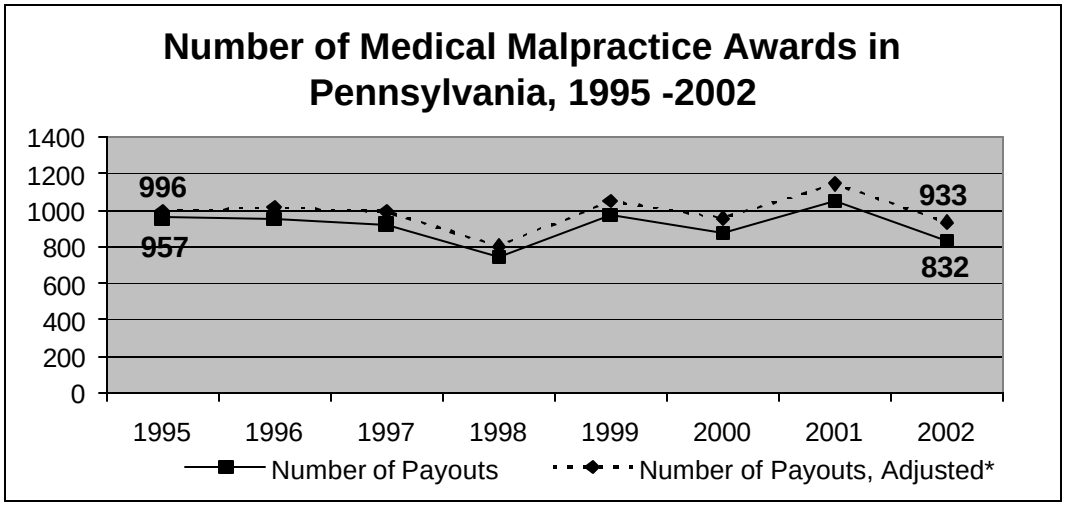
Number of Medical Malpractice Awards Has Decreased in Pennsylvania

Federal government statistics contained in the National Practitioner Data Bank (NPDB) show no evidence that Pennsylvania has experienced the sort of spike in medical malpractice awards to injured patients that would justify a sharp increase in the premiums charged to physicians by insurers. In fact, between 1995 and 2002, both the annual number of awards and the rate of awards per 100 physicians decreased.

- **The annual number of medical malpractice awards in Pennsylvania declined at least 6.3 percent and as much as 13.1 percent from 1995 to 2002.** According to the National Practitioner Data Bank, there were 957 medical malpractice awards paid in Pennsylvania in 1995, and 832 awards paid in 2002 – a decrease of 125, or 13.1 percent. If this number is adjusted by adding certain payments by the state supplemental fund to the total [See Figure 1 and accompanying note], the number of awards was 996 in 1995 and 933 in 2002 – still a decrease of 63 awards, or 6.3 percent.

- **The rate of medical malpractice awards per Pennsylvania physician dropped at least 9.2 percent and as much as 16 percent from 1995 to 2002.** Based on the total number of awards reported by the NPDB, the number of malpractice awards per 100 Pennsylvania doctors was 2.81 in 1995 and dropped to 2.36 in 2002 – a drop of 16 percent. [See Figure 2] If this ratio is based on the adjusted number of total awards [See Figure 2 and accompanying note], the rate of awards per 100 doctors dropped from 2.92 in 1995 to 2.65 in 2002 – a drop of 9.2 percent].

Figure 1



Source: National Practitioner Data Bank, Jan. 1, 1995-Dec. 31, 2002.

* *Note*: The National Practitioner Data Bank determines the number of awards in Pennsylvania by taking the total number of reports and subtracting those payouts made by the state's supplemental fund, because the fund payouts are frequently duplicative. The adjusted number in this table adds back those fund payouts that appear *not* to be duplicative and appear *not* to supplement an insurer's payout.

Figure 2

Number of Medical Malpractice Awards per 100 Physicians In Pennsylvania, 1995 – 2002

	1995	1996	1997	1998	1999	2000	2001	2002
Total Awards (Adjusted)*	957 (996)	949 (1,013)	923 (993)	744 (802)	975 (1,050)	875 (956)	1,047 (1,143)	832 (933)
Awards per 100 Physicians (Adjusted)*	**2.81** (2.92)	**2.76** (2.95)	**2.70** (2.90)	**2.17** (2.34)	**2.85** (3.07)	**2.53** (2.76)	**2.98** (3.25)	**2.36** (2.65)

Sources: National Practitioner Data Bank, Jan. 1, 1995-Dec. 31, 2002, Table 6; and Mcare records detailing number of physicians that have paid into the fund as presented by letter from M. Diane Koken, Insurance Commissioner to Senators Armstrong, Wagner, Greenleaf and Costa, November 3, 2003

* *Note:* Reflects results of adjustment made to NPDB totals. For explanation, see note accompanying Figure 1.

Mcare/CAT Fund Claims, Cases & Payouts Have Been Stable the Past Five Years

Advocates of limiting damages recoverable by victims of medical negligence have claimed that "runaway juries" have caused malpractice awards to "skyrocket" in order to convince politicians and the media that they are being victimized by an explosion of large jury verdicts. In fact, occasional large verdicts may grab headlines but they do not reflect broader trends.

All doctors practicing medicine in Pennsylvania are required by law to buy medical malpractice insurance and they all pay into the Medical Care Availability and Reduction of Error Fund,[1] or Mcare (previously the CAT fund). This is a useful source of data on medical malpractice trends because it covers all doctors and it primarily pays out damages for cases that result in higher damage awards – exactly the types of cases that proponents of tort law changes say need to be curbed.

Claims filed with, cases paid by and the total payouts made by Mcare/CAT fund for the years 1999 through 2003 do not support the claim of dramatic increases in the number of lawsuits or malpractice payouts. In fact, the data shows that the number of cases and claims have declined and the total amount of payouts are stable when adjusted for medical care services inflation.

- The number of defendants (claims) on whose behalf Mcare has made payouts declined from 706 in 1999 to 699 in 2003. [See Figure 3]

- The number of cases that Mcare has made payouts on has dropped from 580 in 1999 to 542 in 2003 – a decrease of 6.5 percent. [See Figure 4]

Figure 3

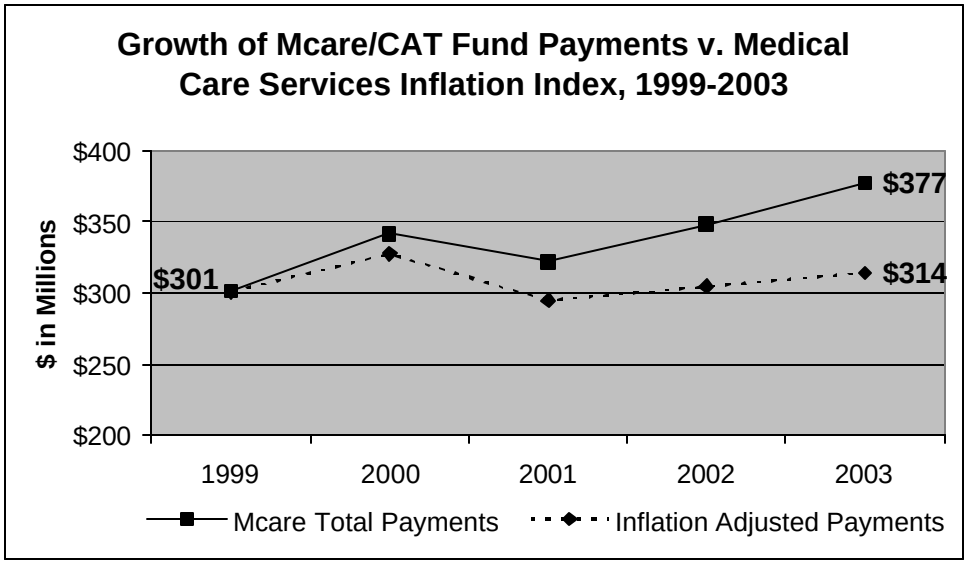
Number of Mcare Claims & Cases 1999-2002

Year	Number Claims	Number Cases
1999	706	580
2000	699	544
2001	691	548
2002	674	534
2003	699	542
Increase/ Decrease	**-.01%**	**-6.5%**

Source: Rosanne T. Placey, Press Secretary/Communications Officer, Pennsylvania Insurance Department, Office of Policy, Enforcement and Administration, Claims Comp 99-03 pv.xls.

- In 1999 Mcare paid a total of $300.8 million for all claims against the fund. By 2003 the total paid out for all claims had risen to $376.8 million – an increase of 6.3 percent per year. However, when adjusted for increases in medical care services inflation, payouts were $314.0 million – only a 4 percent increase over four years, or 1 percent a year. The system clearly is not "out of control; in fact it is quite stable." [See Figure 4

Figure 4



Source: "Monthly Comparison of Settled Claims," table provided to Public Citizen by Pennsylvania Department of Insurance, Office of Policy, Enforcement and Administration, Feb. 27 2004.

Large Malpractice Verdicts Have Declined Sharply in Pennsylvania

Occasional mega-awards in medical negligence lawsuits grab headlines, even if they do not reflect broader trends. But factors such as insurance policy limits and drawn-out appeals by defendants often result in payouts that are considerably less than juries award to injured patients.

These facts, however, have not stopped doctors, hospitals and other health care providers from using anecdotal evidence to convince politicians and the media that they are being victimized by an explosion of large jury verdicts. But their anecdotes are nothing short of misleading.

- **The number of million-dollar jury verdicts fell by 50 percent from 2000 to 2002.** The number of jury verdicts of $1 million or more declined from 44 in 2000 to 22 in 2002. And the overall amount of these awards decreased by over 75 percent, from $415 million to $93 million. [See Figure 5]

Figure 5

Number of Verdicts of $1 Million or More in Pennsylvania

Year	$1 – $4.9 Million	$5 - $9.9 Million	$10 Million or more	Total Awards in Millions
2000a	25	9	10	$415
2001b	29	3	5	$185
2002c	16	4	2	$93

Sources: (a) Pennsylvania Department of Insurance, Table "Plaintiff Verdict Report for 2000."
(b) Pennsylvania Department of Insurance, Table "2001 PA Medical Malpractice Verdicts".
(c) Pennsylvania Department of Insurance, Table "2002 Jury Verdicts for Med Mal Cases".

In addition, a study by two senior Philadelphia judges found that in that city the number of big-money jury awards in malpractice cases dropped by one-third in 2001. While city juries awarded more than $1 million in 30 cases in 2000, that number dropped to 20 cases in 2001.[2] In 2002, that number declined even further – to 14 – a drop of more than 50 percent from 2000.[3]

New Procedural Rules Have Resulted in a Dramatic Decline in Medical Malpractice Filings in Philadelphia

The Pennsylvania Supreme Court in January of 2003 amended the civil procedure rule governing the proper venue for medical malpractice cases so that actions could only be brought in the counties in which they arose. In addition, the court adopted a new civil procedure rule that requires plaintiffs in medical malpractice cases to submit a certificate of merit signed by their lawyer stating that a licensed professional has reviewed the case and found that the defendant's conduct fell outside of the professional standards of care and caused the plaintiff harm. It is impossible to know what impact these new rules will have on medical malpractice filings throughout the state because a central tracking system does not yet exist for medical malpractice cases. The Common Pleas Court in Philadelphia has tracked its medical malpractice filings, however, and the new rules appear to have made a difference.

- **The number of medical malpractice cases filed in Philadelphia dropped 58 percent in 2003.** In 2003, 572 medical malpractice cases were filed in Philadelphia, compared with 1,352 in 2002 – a 58 percent drop.[4] It's hard to know whether cases were filed elsewhere or simply not filed.

- **Almost 300 cases were transferred out of Philadelphia to other counties.** By the end of 2003, at least 298 medical malpractice cases had been transferred out of Philadelphia to other counties. This represents 15.9 percent of the court's medical malpractice inventory.

Changes to venue rules have ended the practice of bringing malpractice cases arising outside Philadelphia in Philadelphia's courts. The number of filings in Philadelphia has dropped dramatically. It is likely that awards in cases now heard in the county where the incident took place will be substantially smaller.

Philadelphia had about 48 percent of the medical malpractice cases filed in Pennsylvania prior to these changes.[5] The city is regularly used as the poster child by those claiming a constitutional amendment must be passed to limit damage awards. Given the dramatic decrease in the city's case filings, the pressure surely should be off for further restrictions to patients' legal rights. In fact, the president of the Delaware Valley Healthcare Council, Andrew Wigglesworth, has predicted that the decrease in cases filed in Philadelphia "should produce significant savings."[6]

There Is No Credible Evidence of a Doctor Exodus

Leaders of the medical community continue to insist that the quality of Pennsylvania's health care is jeopardized by the relocation of doctors to other states that have enacted limits on patient rights and are perceived to be "doctor friendly." They maintain that Pennsylvania's reserve of qualified physicians is dangerously low and that the state is having difficulty attracting new, young doctors. Statistics from the state Insurance Department reveals that the opposite is true.

- **The number of Pennsylvania doctors rose 5.6 percent from 1994 to 2002.** In 1994, 33,321 physicians paid into the state's Medical Care Availability and Reduction of Error Fund, or Mcare Fund. In 2002, the last year for which data is available, the number of participating physicians had risen to 35,180 – an increase of 1,859, or 5.6 percent. [See Figure 6]

Figure 6

Licensed Physicians and Osteopaths in Pennsylvania, 1994-2004

Year	No. of Physicians
1994	33,321
1995	34,095
1996	34,333
1997	34,196
1998	34,316
1999	34,170
2000	34,580
2001	35,131
2002	35,180
2003	N/A
2004	N/A
Increase 1994 - 2002	**1,859 5.6%**

Source: Pennsylvania Department of Insurance as reported by Commissioner M. Diane Koken's letter of November 3, 2003 to Senators Armstrong, Wagner, Greenleaf and Costa.

- **Mcare physician participation numbers are the best indicator of the number of physicians actively practicing in Pennsylvania.** Figures for physician population are the numbers of physicians paying to participate in the state's Mcare Fund, which is mandatory for all practicing physicians and is operated by the state insurance department. According to the insurance commissioner, Mcare collects mandatory assessments but does not independently collect additional physician population data. The department provided the state Senate with the aggregate number of physicians (excluding podiatrists and nurse midwives) used above.

- **The number of physicians grew at a considerably faster rate than Pennsylvania's overall population.** The state's overall population grew 3.3 percent in the nineties, from 11.8 million in 1990 to 12.3 million in 2000, compared to physician growth of 5.6 percent.[7]

Note on statistics: Numbers used for the physician population are the numbers of doctors paying to participate in the state's Mcare fund, which is operated by the Insurance Department. According to the insurance commissioner, Mcare collects mandatory assessments but does not independently collect additional physician population data.[8] The Department provided the state Senate with the aggregate number of physicians (excluding podiatrists and nurse midwives) used for Figure 6 (above).

Ratio of Doctors to Residents Has Increased Faster in Pennsylvania than in Neighboring States

Data compiled by the American Medical Association indicates the ratio of doctors-to-residents has grown steadily in Pennsylvania – and its growth has been greater than in neighboring states, including those that impose caps on malpractice payouts.

- **From 1985 to 2001, the ratio of physicians per 1,000 Pennsylvania residents grew 37.2 percent.** In comparison, during the same period this measurement increased at a slower rate in five neighboring states, two of which had caps on malpractice damage awards in place. [See Figure 7]

  Growth rates for the ratios in neighboring states include 22.5 percent in Maryland, which has a $635,000 cap (adjusted annually) on non-economic damages; 34.9 percent in New Jersey; 34.2 percent in Ohio, where a cap was enacted in 2003; 29.9 percent in New York, which has no caps; and 29.0 percent in Virginia, which has an overall cap of $1.7 million on all malpractice awards.

Figure 7

Physician/Population Ratios for Pennsylvania and Neighboring States, 1985-2001

Year	Physicians Per 1,000 Population					
	Pennsylvania (No Caps)	**New Jersey** (No Caps)	**Ohio**	**New York** (No Caps)	**Virginia** (Caps)	**Maryland** (Caps)
1985	2.34	2.43	1.99	3.18	2.14	3.34
1990	2.56	2.67	2.13	3.39	2.33	3.60
1995	3.01	3.02	2.42	3.91	2.53	3.84
2001	3.21	3.28	2.67	4.13	2.76	4.09
Percent Change 1985-2001	+37.2%	+34.9%	+34.2%	+29.9%	+29.0%	+22.5%

Source: American Medical Association, "Nonfederal Civilian Population, and Physician/Population Ratios for Selected Years 1975-2001," table 5.17, "Physician Characteristics and Distribution in the U.S.," 2002-2003 and prior editions.

Vital Information about Medical Malpractice in Pennsylvania Is Lacking

Doctors and their political allies have made numerous pronouncements that the number of medical malpractice lawsuits in Pennsylvania has exploded in recent years. This explosion, they claim, is threatening patients' access to medical care, particularly with regards to high-risk specialties such as obstetrics and surgery. However, neither of these assertions are verifiable because no one knows how many claims are actually being filed or how many doctors the state has in various specialties.

Is Pennsylvania ready to take a step of constitutional proportions before all the pertinent facts have been gathered? Decision makers must have access to complete information before taking the extraordinary step of amending the state's constitution to cap an injured patient's compensation.

Below are examples of important information policy makers do not have about medical malpractice in Pennsylvania:

- **The number of medical malpractice cases filed annually in the state.** In January 2004, the state Supreme Court ordered local courts to begin tracking the number of medical malpractice cases filed and their outcomes.[9] Prior to that time, each county was responsible for administering its own claim system, and many did not track claims by subject matter. It is impossible to verify charges that an "explosion" in the number of claims filed has occurred until local courts are given an opportunity to comply with the Supreme Court's order. In fact, data from the National Center for State Courts shows that the number of claims filed per 100,000 population decreased 1 percent between 1992 and 2001.[10]

- **The number of Pennsylvania doctors in any given specialty.** The only source of reliable data on the number of doctors practicing in Pennsylvania by specialty is the American Medical Association's Physician Masterfile, which has been used by researchers to track physician migrations. However, medical lobbyists have steadfastly refused to release this data during the debates on malpractice policy, choosing instead to rely on unsubstantiated anecdotes. As reported elsewhere in this report, the overall number of doctors in Pennsylvania *increased* 5.6 percent from 1994-2002 during a time when Pennsylvania's overall population only increased 3.3 percent. It is impossible to verify that the numbers of certain types of physicians are declining, let alone that certain types of doctors are fleeing the state because of the medical malpractice "crisis."

- **The portion of medical malpractice payouts that comprise economic and non-economic damages.** The push for "caps" on medical malpractice damages has focused on non-economic awards – but there is no current means of determining the breakdown of damages that are economic (primarily lost income and medical care) and non-economic (pain and suffering and lost quality of life due to brain damage, paralysis, disfigurement and other injuries). In many large malpractice awards, substantial amounts may be attributed to economic losses – *not* non-economic damages.

Congressional Watchdog Agency Finds Claim of Malpractice Insurance "Crisis" Unsubstantiated – Especially in Pennsylvania

In Pennsylvania 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 Pennsylvania Medical Society contends that patients in Pennsylvania face a "real crisis" with regard to physician supply and access to medical care.

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.

- **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.[11]

    - 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."[12] (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."[13] 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."[14]

    - The volume of medical care delivered to patients in the five crisis states had *increased* during the so-called crisis period.[15]

    - 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.[16]

- 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 orthopaedic 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."[17]

- 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."[18]

- 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."[19]

- **Pennsylvania-specific findings made by the General Accounting Office.**

  - "In Pennsylvania, despite reports of physician departures, the number of physicians per capita in the state has increased slightly during the past 6 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… Physicians practicing in Pennsylvania increased slightly between 1997 and 2001 from 2.6 to 2.8 per thousand in the population and have remained essentially unchanged between 2001 and 2002 at 2.8 per thousand in the population."[20]

  - "Departures of orthopedic surgeons comprise the largest single reported loss of specialists in Pennsylvania. Despite these reported departures, the rate of orthopedic surgeries among Medicare enrollees in Pennsylvania has increased steadily for the last 5 years, as it has nationally."[21]

  - "Contrary to reports of reductions in mammograms in Florida and Pennsylvania, our analysis showed that utilization of these services among Medicare beneficiaries is higher than the national average in both Florida, where utilization rates have recently increased, and in Pennsylvania, where the pattern of utilization has not recently changed. We also contacted selected hospitals and mammography facilities reported to have had problems

in these two states… Representatives from both Pennsylvania mammography facilities contacted told us that increased demand for radiology services was the primary cause for longer wait times."[22]

- "For example, we analyzed rates of all procedures performed by orthopedic surgeons in Pennsylvania and found them to be growing."[23]

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.

- **In December, 2003, 17 new entities were approved to offer medical malpractice insurance in Pennsylvania**. The Insurance Department's announcement of the additional insurance carriers illustrates the temporary nature of the "hard" market that drove some insurers to drastically raise rates or discontinue offering medical malpractice policies.[24]

- **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.[25]

- **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.[26] 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."[27]

- **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.[28]

- **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."[29] 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."[30]

- **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."[31]

- **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."[32]

- **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."[33] 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."[34]

  > "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."[35]

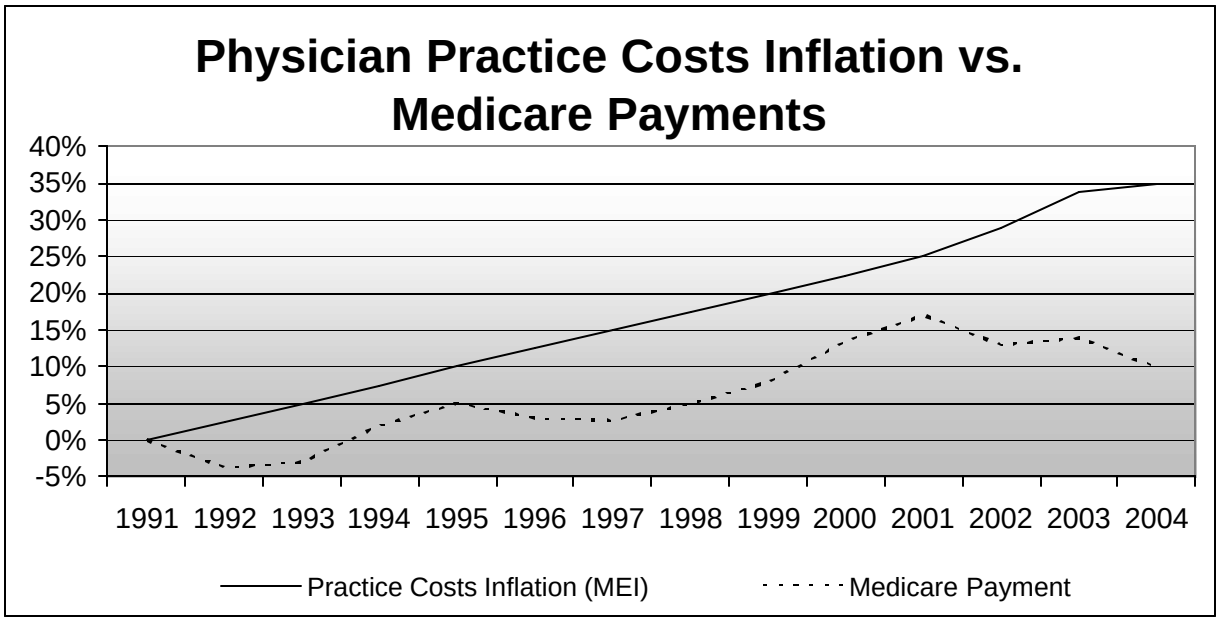
Reduced Fees – Not Insurance Rates – Are The Biggest Financial Burden on Doctors

Doctors across the country have seen their fees slashed in recent years as managed care companies tried to increase profits, and government programs, such as Medicare and Medicaid, tried to cut costs. It has gotten so bad that the Pennsylvania Orthopaedic Society and three doctors sued Independence Blue Cross over their payment and reimbursement for services, procedures and products. The class-action case was settled last year for $40 million.[36]

Medicare reimbursement rates no longer come close to keeping pace with increases in doctors' practice expenses. The AMA estimates that since 1991 physician practice costs have risen by 35 percent, but Medicare payments have risen only 10 percent. That means practice costs have risen two-and-a-half times the rate of Medicare payments. [See Figure 8]

This pressure on fees has contributed greatly to doctor stress and sensitivity to any increases in their practice costs. In fact, the long-term reduction in fees paid to doctors represents a much

Figure 8



Sources: American Medical Association Web site, based on physician practice cost inflation (Medicare Economic Index – MEI) all years, Centers for Medicare and Medicaid Services (CMS); 1992-97 payments, Physician Payment Review Commission; 1998-2003 payments, American Medical Association; 2004 projections, CMS.

more significant burden than the temporary spike in malpractice insurance rates that doctors have recently experienced.

On the other hand, medical malpractice premiums account for a very small share of a physician's practice revenue – ranging from 2.2 percent to 7.6 percent.[37] Moreover, malpractice insurance costs are usually far less than items such as staff salaries and office space.

The tort system is a convenient whipping boy for doctors who will continue to chafe from cost containment measures, but victims of medical negligence should not be made to compensate for declining reimbursement rates.

Rather than Facing "Runaway Litigation," Doctors Benefit from a Claims Gap

Although no comparable studies have been cited in Pennsylvania, there is convincing evidence from around the nation that the majority of patients who suffer injuries from medical malpractice never file lawsuits.

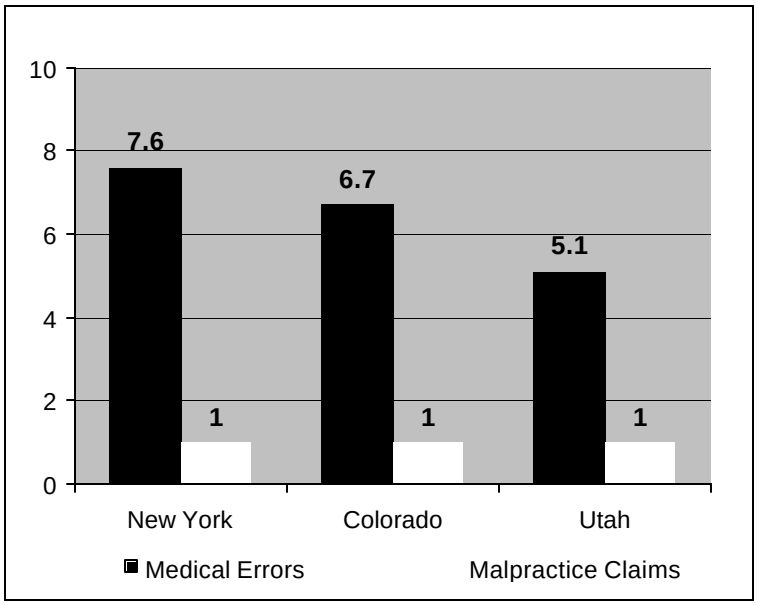
- **A landmark Harvard Medical Practice Study found that only a small percentage of medical errors result in lawsuits.** Twelve years ago, Harvard researchers using a sample of hospitalizations in New York State compared medical records to claims files. They found that only one in 7.6 instances of medical negligence committed in hospitals results in a malpractice claim.[38] Researchers replicating this study made similar findings in Colorado and Utah.[39] [See Figure 9]

- **Actual numbers collected by government agencies show a similar claims gap.** A Florida statute requires hospitals to report "adverse incidents," defined as "an event over which health care personnel could exercise control" that results in death or injury. Tables prepared by Florida's Agency for Health Care Administration have compared reports of adverse incidents to filing of new malpractice claims. From 1996 through 1999, Florida hospitals reported 19,885 incidents but only 3,177 medical malpractice claims.[40] In other words, for every six preventable medical errors only one claim is filed. [See Figure 10]

- **Expenditures on medical liability comprise less than 1 percent of overall health care costs.** As the Congressional Budget Office reported, "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."[41]

Figure 9

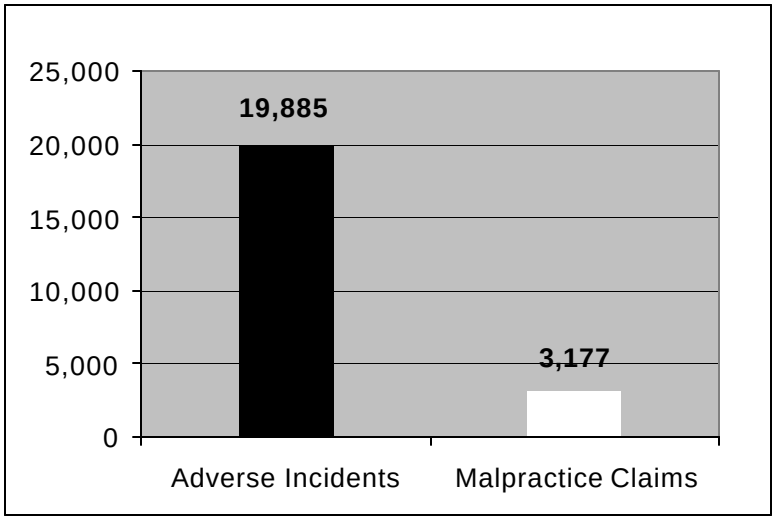
Malpractice Claims Gap: Ratio of Medical Errors to Claims Filed



Source: Harvard Medical Practice Study Group, *Patients, Doctors and Lawyers: Medical Injury, Malpractice Litigation, and Patient Compensation in New York* (1990); 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).

Figure 10

Florida Malpractice Claims Gap: 1996-1999
Ratio of Medical Errors to Claims Filed



Source: The Agency for Health Care Administration, Division of Health Quality Assurance. Reported malpractice claims by district compared to reported adverse incidents 1996, 1997, 1998, 1999.

Empirical Evidence Does not Confirm the Existence of "Defensive Medicine" – Patient Injuries Refute It

In many states, when questions about malpractice "reform" arise, doctors and their lobbyist's claim that a fear of litigation has prompted physicians to perform additional medical tests – resulting, they say, in higher costs and risks to patients. A search of studies and scholarly literature, however, finds no empirical evidence that doctors are actually practicing this sort of "defensive" medicine:

- **A search of the scholarly literature on medicine will turn up dozens of studies documenting the incidence of medical errors, but not one peer-reviewed study documenting purely defensive medicine.** One might laugh at the spectacle of a lobbying campaign constructed around a flimsy theory unsupported by any empirical evidence. Unfortunately, the evidence *disproving* the theory is so overwhelming and compelling as to be truly frightening. Several recent studies demonstrate that current disincentives to unsafe and sloppy practices are inadequate, and show how much more dangerous medical care would be if deterrents were further weakened.

- **The Congressional Budget Office has rejected the defensive medicine theory.** The Congressional Budget Office (CBO) was asked to quantify the savings from reduced "defensive medicine" if Congress passed H.R. 5. This bill, which contained very stringent restrictions on patients' ability to recover damages, passed the U.S. House in 2003. 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. …[u]sing a different data set, CBO could find no statistically significant difference in per capita health care spending between states with and without malpractice tort limits.[42]

- **The General Accounting Office has rejected the defensive medicine theory.** Medical provider groups admitted to GAO investigators that "factors besides defensive medicine concerns also explain differing utilization rates of diagnostic and other procedures. For example, a Montana hospital association official said that revenue-enhancing motives can encourage the utilization of certain types of diagnostic tests, while officials from Minnesota and California medical associations identified managed care as a factor that can

mitigate defensive practices. According to some research, managed care provides a financial incentive not to offer treatments that are unlikely to have medical benefit."[43]

A 1996 study by two economists has been cited by the Bush Administration to argue that tort "reform" will yield a 5 to 9 percent savings in health care costs from decreased defensive medicine. "However," said the GAO, "this study did not control for other factors that can affect hospital costs, such as the extent of managed care penetration in different areas. When controlling for managed care penetration in a 2000 follow-up study, the same researchers found that the reductions in hospital expenditures attributable to direct tort reforms dropped to about 4 percent. Moreover, preliminary findings from a 2003 study [by CBO] that replicated and expanded the scope of these studies to include Medicare patients treated for a broader set of conditions failed to find any impact of state tort laws on medical spending."[44]

- **Defensive medicine hasn't prevented wrong-patient surgery.** New York hospitals reported 27 instances of invasive procedures performed on the wrong patient between April 1998 and December 2001.[45] There were nine such instances in Florida in 2001.[46] In trying to determine how such shocking errors could occur, researchers analyzed one case in detail. The case study determined that medical personnel had ignored "many seemingly clear signals that they were subjecting the wrong patient to an invasive procedure." In this case, "defensive medicine" measures would have included follow-up questioning or record-checking when the patient told personnel she had not been admitted for cardiac treatment. Surely if the medical providers were frightened of lawsuits they would have made such minimal inquiries.

- **Defensive medicine hasn't prevented medication errors.** An Auburn University study of 36 hospitals and nursing homes in Colorado and Georgia found that on average, 19 percent of medication doses were given in error, with 7 percent judged to be potentially harmful.[47] The authors said this amounts to about 40 potential adverse drug events per day in a typical 300-patient facility. The errors were made in spite of the presence of observers from the research team – who could easily have been called as witnesses in a medical liability lawsuit. An earlier study by Boston researchers estimated that there are some 500 preventable adverse drug events in the average hospital each year, in spite of the fact that "drug injuries frequently result in malpractice claims, and in a large study of closed claims… accounted for the highest total expenditure of any type of procedure-related injury."[48]

- **Defensive medicine hasn't prevented mammography errors.** The *New York Times* reported in June 2002 some very disturbing facts about errors committed by radiologists in reading mammograms.[49] Studies indicate that some doctors and clinics miss as many as one in three cancers. Despite the possibility of lawsuits, doctors with no aptitude for mammography continue to read mammograms. Clinics continue to employ doctors who read too few mammograms to keep their skills sharp. It appears that only reviews by regulators spur doctors and clinics to meet minimum standards.

- **Defensive medicine hasn't prevented hospital infections**. The *Chicago Tribune* reported on July 21, 2002 that some 75,000 Americans die each year because of infections acquired in hospitals that "were preventable, the result of unsanitary facilities, germ-laden instruments, unwashed hands and other lapses."[50] If medical providers fear being sued over

the slightest lapse, why would doctors and nurses neglect to take the most elementary precautions of washing their hands and changing scrub uniforms? Why would American hospitals "have collectively pared cleaning staffs by 25 percent since 1995"?[51] Previously, consultants retained by medical provider groups have argued that medical providers *overspend* on precautionary measures by five to nine percent.[52]

- **Defensive medicine hasn't caused hospitals to keep nursing staffs up-to-strength.** Two reports published in the past 6 months concluded that patients in hospitals where nurses had heavier workloads had a higher risk of dying.[53] One report found specifically that each additional patient per nurse corresponded to a 7 percent increase in both patient mortality and deaths following complications.[54] Nevertheless, nursing shortages persist, even though the defensive medicine theory predicts.

Few Malpractice Lawsuits Are "Frivolous"

Lobbyists for the Pennsylvania Medical Society have claimed that medical liability insurance will become affordable only if patients and their lawyers can be discouraged from filing lawsuits.

President Bush and some members of the U.S. Senate and House have made similar comments about "frivolous lawsuits" and "junk lawsuits" in their efforts to promote a federal medical malpractice bill that would place caps on pain-and-suffering awards to injured patients.[55]

In reality, 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.[56] If the case goes to trial, the costs can easily be doubled.[57] 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.[58] 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.

- **The small numbers 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.[59] 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.

Section II

The Real Medical Malpractice Crisis Is Inadequate Patient Safety

The Costs of Medical Malpractice to Pennsylvania's Patients & Consumers vs. Pennsylvania's Health Care Providers

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.[60] 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 Pennsylvania should be measured by the cost to patients and consumers, not the premiums paid by health care providers to their insurance companies. Extrapolating from the IOM findings, we estimate that there are 1,920 to 4,277 preventable hospital deaths in Pennsylvania each year that are due to medical errors. The costs resulting from preventable medical errors to Pennsylvania's residents, families and communities is estimated at $742 million to $1.3 billion each year. But the cost of medical malpractice insurance to Pennsylvania's health care providers is just over $683 million a year.[61] [See Figure 11]

Figure 11

1,920 - 4,277
Preventable Hospital Deaths Due to Medical Errors Each Year

$742 million - $1.3 billion
Costs Resulting from Preventable Medical Errors Each Year

$683 million
Cost of Pennsylvania Health Care Providers' Annual Medical Malpractice Premiums

Sources: Preventable hospital deaths and costs are prorated based on population and based on estimates in To Err is Human, Institute of Medicine, November 1999. Malpractice premiums are based on draft report to National Association of Insurance Commissioner's Property and Casualty Committee, "Medical Malpractice Insurance – A Study of Market Conditions," table 13, "2002 Medical Liability Profitability Results By State," Dec. 3, 2003; and information on surcharges paid to the state's Medical Professional Liability Catastrophic Loss Fund reported by the Pennsylvania Insurance Department.

Only 5.3 Percent of Doctors Are Responsible for 56 Percent of the Malpractice Payouts Nationwide

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 numbers come up more often than others. A small percentage of doctors have attracted multiple claims, and it is these doctors who are responsible for much of the malpractice in this country.

- According to the federal government's National Practitioner Data Bank, which covers malpractice judgments and settlements since September 1990, just 5.3 percent of the nation's doctors have been responsible for 56 percent of malpractice payouts to patients. [See Figure 12] Overall, these 108,003 doctors, all of whom have made two or more payouts, have paid $23.7 billion in damages. [Note: Given the multiple payments made by private insurers and Pennsylvania's Mcare fund on behalf of the same doctor for the same incident, it is difficult to determine with precision the number of the state's doctors who are repeat offenders, which is why national data is used here.]

- Even more surprising, just 2 percent of all doctors (59,590), each of whom has paid three or more malpractice claims, were responsible for 30.9 percent of all payouts.

- 83.2 percent of the nation's doctors have never made a malpractice payout.

Figure 12

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

Number of Payout Reports	Number of Doctors Who Made Payouts	Total Number of Payouts	Percent/Total Doctors (736,264)*	Percent of Total Number of Payouts	Total Amount of Payouts
All	123,492	192,808	16.8%	100.0%	$41,834,825,200
1	84,805	84,805	11.5%	44.0%	$18,116,880,900
2 or more	38,687	108,003	5.3%	56.0%	$23,717,944,300
3 or more	14,393	59,590	2.0%	30.9%	$12,981,834,050
4 or more	6,494	36,003	0.9%	18.7%	$7,856,619,650
5 or more	3,243	23,070	0.4%	12.0%	$4,960,218,580

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

* Based on number of physicians 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

Nationwide, doctors are permitted to repeatedly commit medical negligence and errors without being reined in by state medical boards. According to National Practitioner Data Bank data, U.S. doctors can make up to 10 malpractice payouts without facing more than a one-third chance that some disciplinary action (license suspension or revocation, or a limit on clinical privileges) will be taken against them. [See Figure 13]

- Only 11.1 percent (1,612 of 14,393) of the nation's doctors who made three or more malpractice payouts were disciplined by their state boards.

- Only 14.4 percent (934 of 6,494) of the nation's doctors who made four or more malpractice payouts were disciplined by their state boards.

- Only 17.2 percent (559 of 3,243) of the nation's doctors who made five or more malpractice payouts were disciplined by their state boards.

Figure 13

U.S. Doctors with Two or More Medical Malpractice Payouts Who Have Been Disciplined (Reportable Licensure Actions), Sept. 1, 1990-Sept. 30, 2003

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	38,687	3,093	8.0%
3 or more	14,393	1,612	11.1%
4 or more	6,494	934	14.4%
5 or more	3,243	559	17.2%
10 or more	381	125	32.8%

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

Examples of Repeat Offenders Who Have Gone Undisciplined

The extent to which Pennsylvania doctors make multiple payouts to patients for medical malpractice claims and are not disciplined is illustrated by the following National Practitioner Data Bank descriptions of 13 physicians licensed in Pennsylvania who have made between 4 and 15 malpractice payouts totaling at least *$5 million* yet have not been disciplined by the state:

- **Physician Number 33075** made at least 14 malpractice payments between 1993 and 2003, three times for failures to diagnose, twice for improper performance of surgery, twice for unspecified obstetrics errors, twice for unidentified treatment errors, a delay in treatment of identified fetal distress, a retained foreign body in surgery, an unspecified diagnosis error, a failure to obtain consent and a failure to manage a pregnancy. The damages add up to $9,840,000.

- **Physician Number 43967** made at least 9 malpractice payments between 1995 and 2000, twice for improper performance of surgery, twice for unnecessary surgeries, twice for unidentified equipment errors, a retained foreign body in surgery, operating on a wrong body part and an unspecified surgery error. The damages add up to $8,722,500.

- **Physician Number 33200** made at least 6 malpractice payments between 1991 and 2003, three times for unspecified obstetrics errors, an improper performance of surgery, an improper management of labor and a failure to identify and treat fetal distress. The damages add up to $7,435,000.

- **Physician Number 32522** made at least 15 malpractice payments between 1991 and 2003, four times for improper performances of surgery, three times for unspecified obstetrics errors, twice for failures to manage pregnancies, a failure to diagnose, a retained foreign body in surgery, a failure to obtain consent, an unspecified surgical error, an improperly performed vaginal surgery and an improperly managed labor. The damages add up to $7,295,000.

- **Physician Number 156600** made at least 4 malpractice payments between 2000 and 2003 for a failure to diagnose, an unspecified obstetrics error, a failure to identify and treat fetal distress and a delay in the treatment of identified fetal distress. The damages add up to $6,852,500.

- **Physician Number 118512** made at least 4 malpractice payments between 1998 and 2000, twice for improper performances of surgery, an unspecified surgical error and a failure to obtain consent. The damages add up to $6,472,500.

- **Physician Number 67589** made at least 7 malpractice payments between 1995 and 2002, three times for unspecified surgical errors, a retained foreign body in surgery, an improper

management of surgery, a failure to monitor and an unspecified blood product error. The damages add up to $6,261,250.

- **Physician Number 71202** made at least 5 malpractice payments between 1995 and 2000, twice for improperly managing a course of treatment, a failure to diagnose, an improper performance of surgery and an unspecified surgical error. The damages add up to $6,232,500.

- **Physician Number 56749** made at least 9 malpractice payments between 1994 and 2002, four times for unspecified surgical errors, twice for retained foreign bodies in surgery, a failure to diagnose, an unnecessary surgery and a failure to treat. The damages add up to $5,830,000.

- **Physician Number 176300** made at least 4 malpractice payments between 2001 and 2002, three times for unspecified obstetrics errors and an improper performance of surgery. The damages add up to $5,490,000.

- **Physician Number 33119** made at least 7 malpractice payments between 1990 and 1995, five times for unspecified surgical errors, a failure to diagnose and a delay in surgery. The damages add up to $5,402,500.

- **Physician Number 33072** made at least 5 malpractice payments between 1993 and 2001, twice for failures to diagnose, a wrong diagnosis, a delay in diagnosis and an unspecified treatment error. The damages add up to $5,160,000.

- **Physician Number 34057** made at least 5 malpractice payments between 1992 and 2002 for an improper performance of surgery, an unspecified surgical error, a failure to manage a pregnancy, a retained foreign body in obstetrics and an unspecified obstetrics error. The damages add up to $5,095,000.

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

Generally speaking, doctors have resisted courts' findings of negligent medical care, choosing to fight the system rather 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."

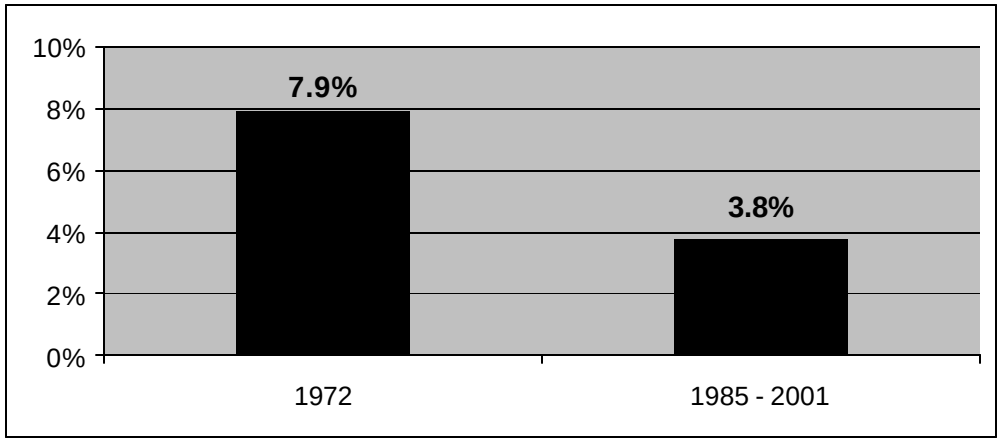
- The number and severity of claims dropped dramatically. In 1972, anesthesiologists were the target of 7.9 percent of all medical malpractice claims, double their proportion among physicians. But from 1985 to 2001, they were targets of only 3.8 percent of claims. [See Figure 14]

- In the 1970s, 64 percent of anesthesiology claims involved permanent disability or death; by the 1990s, only 41 percent did. [See Figure 15]

- 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 16]

Figure 14

Percent of Malpractice Claims Involving Anesthesiologists



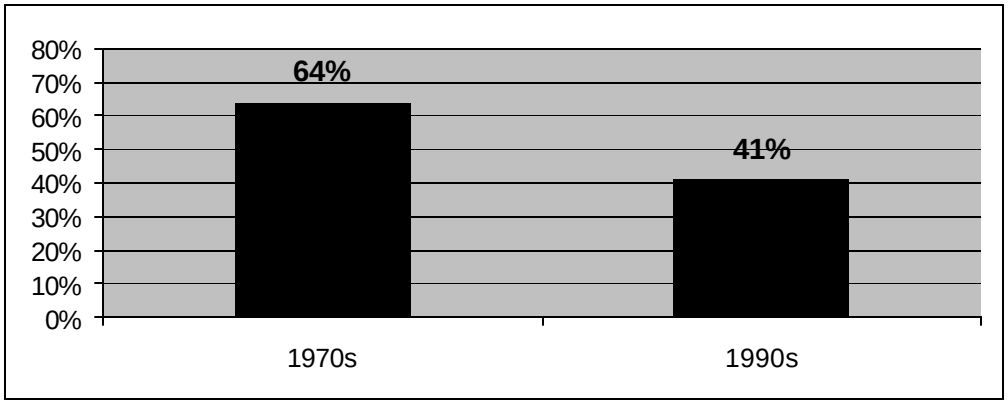
Sources: U.S. Department of Health, Education and Welfare, Secretary's Commission on Medical Malpractice, 1973; Physician Insurers Association of America, Cumulative Data Sharing Report, January 1, 1985 – December 31, 2001.

- 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 17]

- 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 18]

Figure 15

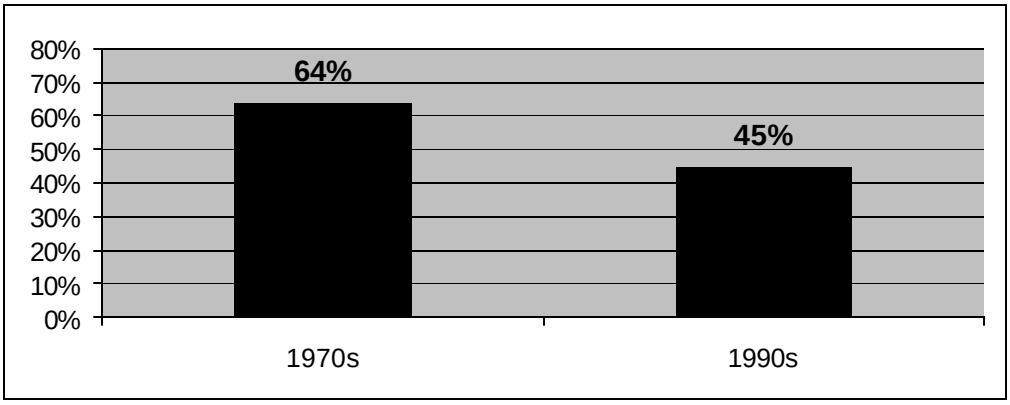
Anesthesia Claims Involving Permanent Disability or Death, 1970s and 1990s



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

Figure 16

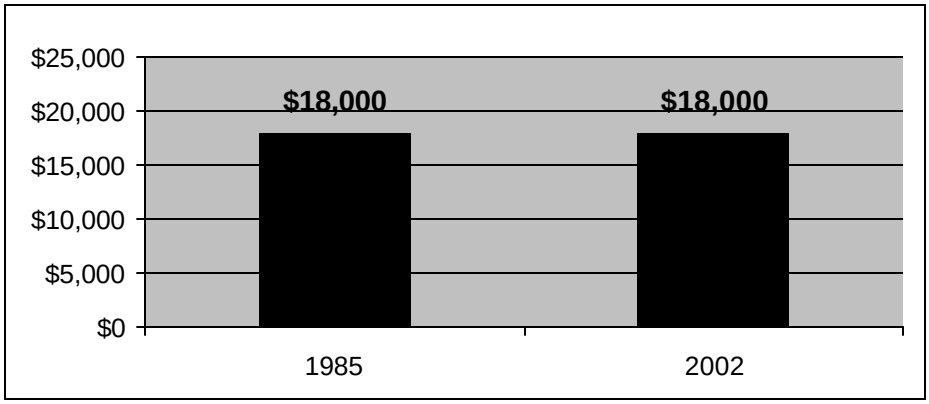
Percent of Anesthesia Claims Closed with Payment, 1970s and 1990s



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

Figure 17

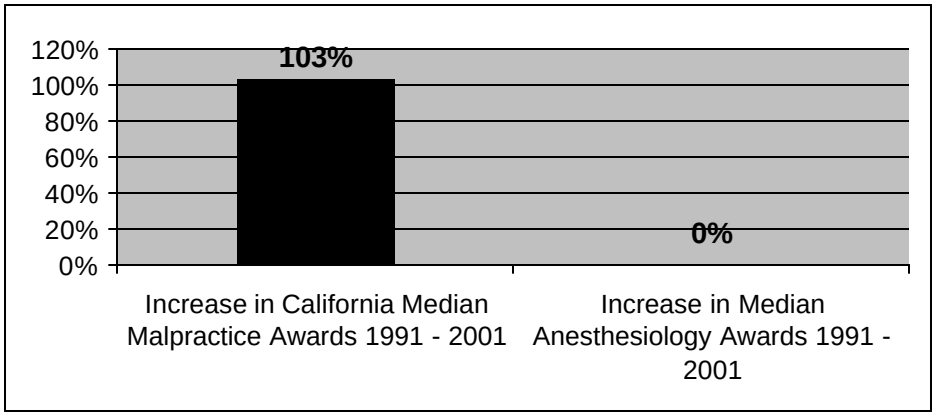
Average Premium for Anesthesiologists 1985 and 2002



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

Figure 18

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.

Section III

Caps on Damages Are Unjust and Offer No Solution to Rising Premiums

Caps on Damages Are Unjust

Doctors and their lobbyists in Pennsylvania 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."[62]

- **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.[63] 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.

- **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.

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.

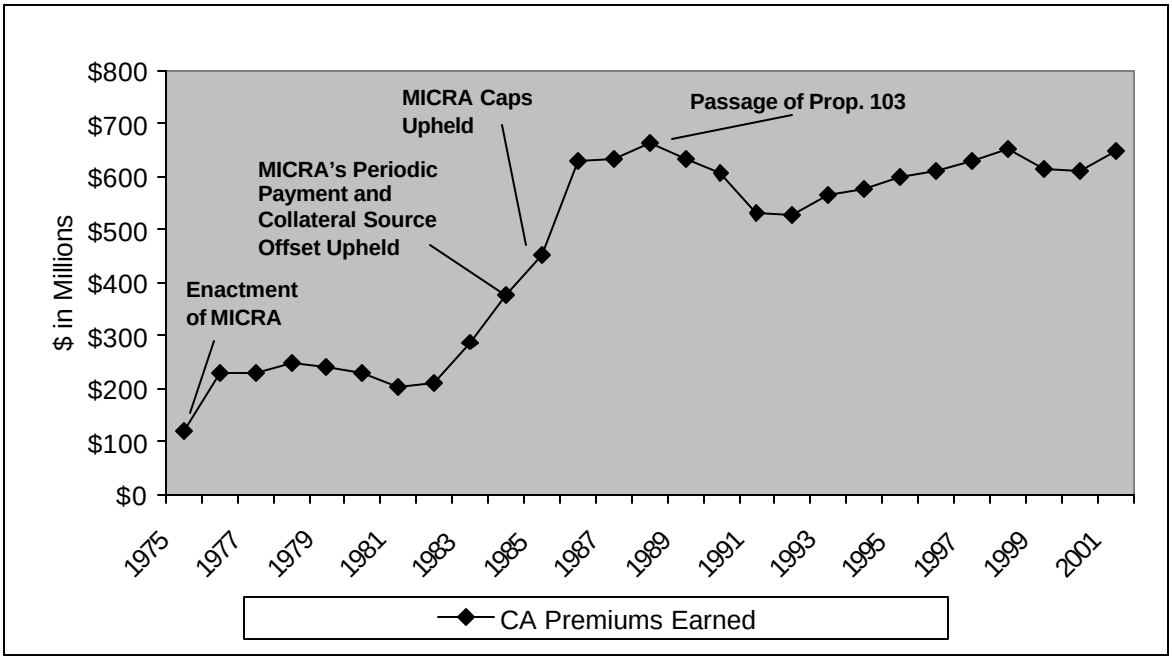
The effect on medical-malpractice insurance premiums was staggering. In the first 12 years of MICRA (1976-1988) malpractice insurance premiums earned (paid) *increased* 190 percent, but under Prop 103 premiums earned *declined* 2 percent from 1988-2001.[64] [See Figure 19]

- **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 constitutionally 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 19

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.

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 Association[65]

"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 Association[66]

"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 Association[67]

"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 Companies[68]

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 California[69]

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.[70]

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 Mississippi[71]

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.[72]

"[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 Issues[73]

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."[74]

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."[75]

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.[76]

"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 Assurance[77]

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 Committee[78]

Damage Caps Don't Guarantee Lower Medical Malpractice Insurance Premiums

Physicians argue that caps on non-economic damages in medical malpractice cases will lower the insurance premiums they pay. But, that is not necessarily the case, as demonstrated by a comparison of the premiums insurers charge doctors in metropolitan Philadelphia (Pennsylvania has no cap) and the premiums they charge in metropolitan Detroit (Michigan limits non-economic damages to $366,000 for non-catastrophic injuries and $635,500 for catastrophic injuries).

A comparison of 2003 rates contained in the Medical Liability Monitor shows that internists, general surgeons and ob/gyns generally pay less in Philadelphia than their counterparts do in Detroit when insured by the same carrier or when comparing rates between the largest insurers in the marketplace. [See Figure 20]

Figure 20

Detroit Area vs. Philadelphia Area Malpractice Premiums

Internist Malpractice Premiums

Detroit Area	
Company and Area	*Premium*
ProNational: Wayne, Oakland, Macomb	$50,063
APCapital: Wayne Co.	$33,514
Average Premiums	
$41,789	

Philadelphia Area	
Premium	*Company and Area*
$28,548	**ProNational:** Philadelphia. & Delaware Cos.
$24,546	**PMSLIC:** Philadelphia
$29,667	**PA JUA:** Delaware & Philadelphia Cos.
Average Premiums	
$27,587	

General Surgeon Malpractice Premiums

Detroit Area	
Company and Area	*Premium*
ProNational: Wayne, Oakland, Macomb	$154,165
APCapital: Wayne Co.	$106,889
Average Premiums	
$130,527	

Philadelphia Area	
Premium	*Company and Area*
$100,019	**ProNational:** Philadelphia. & Delaware Cos.
$108,038	**PMSLIC:** Philadelphia
$131,348	**PA JUA:** Delaware & Philadelphia Cos.
Average Premiums	
$113,135	

OB/GYN Malpractice Premiums

Detroit Area	
Company and Area	*Premium*
ProNational: Wayne, Oakland, Macomb	$154,165
APCapital: Wayne Co.	$133,913
Average Premiums	
$144,039	

Philadelphia Area	
Premium	*Company and Area*
$128,114	**ProNational:** Philadelphia. & Delaware Cos.
$134,335	**PMSLIC:** Philadelphia
$152,730	**PA JUA:** Delaware & Philadelphia Cos.
Average Premiums	
$138,393	

Source: Medical Liability Monitor, 2003 Rate Survey, October, 2003.

Note: Pennsylvania Medical Society Liability Insurance Company (PMSLIC) is Pennsylvania's largest malpractice carrier with $62.3 million in direct premiums written in 2002.[79] ProNational Insurance Company (ProNational) is Michigan's leading writer of medical liability insurance with $50 million in direct premiums written in 2002.[80]

PMSLIC's premiums (including the statutory Mcare surcharge without abatement or other discount) is substantially lower in Philadelphia and Delaware Cos. than the premiums charged by Michigan's largest malpractice carrier in the comparable area of Detroit.

In all of the malpractice carriers surveyed by the Medical Liability Monitor, the premiums reported by the Michigan carriers were consistently higher than Pennsylvania companies in the comparable specialty and geographic area. Most policyholders in Michigan pay higher premiums than their counterparts in Pennsylvania even though Michigan has a cap on non-economic damages.[81]

Caps on Malpractice Awards Do Not Improve Access to Primary Care

There is no apparent relationship between caps on malpractice awards and access to primary medical care. Among the 15 states with the highest percentages of population lacking primary medical care, nine impose malpractice caps. [See Figure 21] In fact, three of the four states with the greatest underserved populations have malpractice caps. Conversely, among the 15 states with the smallest percentages of population lacking primary care, eight do *not* have malpractice caps.[82] Pennsylvania, which has no caps, is ranked *8th* best in the country in population lacking access to primary care percentage.

The Health Professional Shortage Area database maintained by the U.S. Department of Health and Human Services[83] shows that urbanization and affluence are the most frequent predictors of access to medical care.

- **Mississippi had the nation's worst access to medical care years before the current malpractice "crisis."** Mississippi, with just 149 physicians per 100,000 residents, ranks worst in the nation for the percentage of its population that lacks medical primary care. And Mississippi also ranked worst among states in terms of its medically underserved population in 1992 (33.3%),[84] long *before* a so-called "malpractice crisis" was proclaimed in that state.

- **Caps and low payouts to patients haven't made primary care accessible in Utah.** The third worst state for the percentage of its population lacking primary medical care is Utah, which has a $400,000 cap on damages and very low malpractice payouts to patients – ranking 49th nationally for the average size of payouts.[85] "Rural communities in Utah have long had a hard time attracting and retaining specialty physicians," according to a Utah Medical Association spokesman.[86]

- **Idaho also has malpractice caps – as well as a medically underserved population.** Idaho, another state that has a $400,000 cap on non-economic damages, ranks fourth worst in the nation for the percentage of its population that lacks primary care. [87]

- **The AMA claims California's caps attract doctors, but shortages continue to plague primary care.** In 1992, the state with the most medically underserved residents (6.4 million) was California, which has a $250,000 cap on non-economic damages in malpractice cases.[88] The American Medical Association has suggested that doctors leaving Nevada because of high insurance rates were flocking to California.[89] Yet only two months ago, *Hospitals and Health Networks* magazine reported that 35 percent of primary care doctors in San Diego "plan to move, change professions or retire within five years." In the San Diego Medical Society survey, cited by the magazine, "64% of the physician respondents say there's already a doctor shortage in the county; and 71% percent say they have difficulty recruiting doctors."

Figure 21

Percent of Population Lacking Access to Primary Care, States With "Caps" and Without "Caps" – 2000

Rank	State	Malpractice Caps?	Population w/o Access
THE FIFTEEN WORST			
1	Mississippi	No*	26.9%
2	Alabama	Yes	22.7%
3	Utah	Yes	21.0%
4	Idaho	Yes	20.3%
5	District of Columbia	No	19.5%
6	South Dakota	Yes	19.2%
7	Louisiana	Yes	18.3%
8	Wyoming	No	17.9%
9	Missouri	Yes	17.8%
10	Georgia	No	16.3%
11	South Carolina	No	16.0%
12	New Mexico	Yes	15.9%
13	North Dakota	Yes	15.5%
14	Alaska	Yes	14.2%
14	Kentucky	No	14.2%
THE FIFTEEN BEST			
1	Hawaii	Yes	2.9%
2	New Jersey	No	3.5%
3	Vermont	No	3.7%
4	Massachusetts	Yes	4.0%
5	New Hampshire	No	4.3%
6	Delaware	No	4.5%
7	California	Yes	4.9%
8	***Pennsylvania***	***No***	***5.5%***
9	Connecticut	No	5.7%
10	Kansas	Yes	6.0%
11	Maryland	Yes	6.2%
12	Nebraska	No	6.6%
13	Illinois	No	6.7%
14	Ohio	No	7.0%
15	Virginia	Yes	7.2%

Source: *Health Care State Rankings 2001*, Morgan Quitno Press.

* *Note:* Mississippi did not have malpractice award caps during the year covered in this report.

- **Research shows that caps do not prevent doctors from leaving states.** During the last malpractice "crisis" in the late 1980s, researchers at the University of North Carolina studied the migration of doctors to and from rural communities, using data from the AMA Physician Masterfile. They found that the states with the greatest net inflow of rural doctors were North Carolina, Florida, Georgia, and South Carolina – none of which had caps on medical malpractice awards. The biggest losers included Louisiana, which had caps for over a decade, and Missouri, which adopted a cap during the period of the study.[90]

Endnotes

[1] In Pennsylvania, unlike most states, there is a special fund operated by the state that pays part of the larger medical malpractice claims. Doctors must purchase private sector insurance that would pay up to $500,000 per claim. The Medical Care Availability and Reduction of Error Fund (Mcare), previously the Catastrophic Fund (CAT), pays the next layer of coverage, also in the amount of $500,000. Until 2003, all doctors and hospitals in Pennsylvania paid an annual surcharge to the Mcare Fund, and these funds are used to pay claims. Source: Mercyhurst College Civic Institute, *Medical Malpractice Report*, Erie County Medical Malpractice Workgroup, Feb. 9, 2004.
[2] Josh Goldstein, "Malpractice issue may not be about money, study says," *Philadelphia Inquirer*, Feb. 3, 2002.
[3] Pennsylvania Department of Insurance, Table "2002 Jury Verdicts for Med Mal Cases".
[4] Statistics provided by Common Pleas Court in Philadelphia.
[5] "Settlements by Count," table provided to Public Citizen by Pennsylvania Department of Insurance, Office of Policy, Enforcement and Administration, Jan. 15, 2003.
[6] Josh Goldstein, "Medical Lawsuits Plummet in Phila., *Philadelphia Inquirer*, Aug. 31, 2003.
[7] U.S. Census Bureau, No. 18, Resident Population – States: 1980 to 2000. Statistical Abstract of the United States: 2001.
[8] Insurance Commissioner M. Diane Koken, letter to Sens. Armstrong, Wagner, Greenleaf and Costa, Nov. 3, 2003.
[9] *Pittsburgh Tribune-Review*, "State's chief justice seeks malpractice data," Jan. 13, 2004.
[10] National Center for State Courts, Court Statistics Project, "Examining the Work of State Courts, 2002," 2003.
[11] 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.
[12] GAO Study at p. 5.
[13] GAO Study at p. 5.
[14] GAO Study at p. 13.
[15] GAO Study at p. 20.
[16] GAO Study at p. 20.
[17] GAO Study at pp. 13-14.
[18] GAO Study at p. 20.
[19] GAO Study at p. 7.
[20] 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, p. 18.
[21] GAO Study at p. 18.
[22] GAO Study at p. 21.
[23] GAO Study at p. 39.
[24] Information posting by the Pennsylvania Department of Insurance, Dec. 26, 2003.
[25] Congressional Budget Office, "Limiting Total Liability for Medical Malpractice," Jan. 8, 2004.
[26] Americans for Insurance Reform, "Medical Malpractice Insurance: Stable Losses/Unstable Rates," Oct. 10, 2002. See also: http://www.insurance-reform.org/StableLosses.pdf.
[27] Charles Kolodkin, "Medical Malpractice Insurance Trends? Chaos!" International Risk Management Institute. http://www.irmi.com/expert/articles/kolodkin001.asp
[28] "Hot Topics & Insurance Issues," Insurance Information Institute, www.iii.org.
[29] Christopher Oster and Rachel Zimmerman, "Insurers' Missteps Helped Provoke Malpractice 'Crisis,'" *Wall Street Journal* , June 24, 2002.
[30] Charles Kolodkin, Gallagher Healthcare Insurance Services, "Medical Malpractice Insurance Trends? Chaos!" September 2000, available at http://www.irmi.com/expert/articles/kolodkin001.asp.
[31] "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.
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