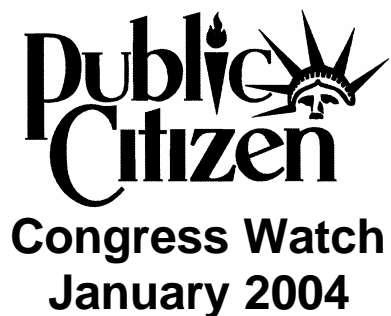


**Public Citizen's Reply to Tillinghast-Towers  
Perrin's Critique of Public Citizen's Report:**

**"The Facts About Medical Malpractice in Maryland"**



# Public Citizen’s Reply to Tillinghast-Towers Perrin

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# Public Citizen's Reply to Tillinghast-Towers Perrin

## Executive Summary

MEDICAL MUTUAL retained consulting firm TILLINGHAST-Towers Perrin to critique PUBLIC CITIZEN's report on medical malpractice, *The Facts About Medical Malpractice in Maryland*, issued in September 2003. TILLINGHAST's critique of Public Citizen's major findings are based on three fatal flaws:

### 1) TILLINGHAST's critique of PUBLIC CITIZEN's use of 1996 data lacks merit:

- TILLINGHAST claims that PUBLIC CITIZEN's use of 1996 as the beginning year for the analysis of trends produces biased results concerning the number of malpractice claims, number of payouts, and the amount of payouts.
- TILLINGHAST failed to provide empirical data that supports its claim that 1996 was an unusually high or distorted year.
- TILLINGHAST claimed that 1996 was an unusually high point, but, when viewed in context with nation-wide data that assertion fails.
- TILLINGHAST speculated, admittedly without knowing, that amendments to the state's arbitration statute may have caused a spike in filings. However the facts do not support that speculation.
- MEDICAL MUTUAL did not claim a "crisis" existed until 2003. If 1996 was in fact an unusual year, MEDICAL MUTUAL's actions were inconsistent with that belief. Moreover, from 1997-2002 MEDICAL MUTUAL returned dividends to its policyholders averaging 27.2 percent a year, or more than 27 cents on each dollar paid in premiums! (P.C. Report, p. 32) As recently as October 2002, the company chairman was touting the company's excellent capitalization and strong balance sheet position.<sup>1</sup>

### 2) TILLINGHAST's critique of PUBLIC CITIZEN's use of National Practitioner Data Bank (NPDB) data lacks merit:

- TILLINGHAST overlooks the fact that the NPDB is the most comprehensive source of information about *physician* medical malpractice claims.
- TILLINGHAST ignores the fact that NPDB data has been widely used by others for similar types of research on medical malpractice claims and payouts, including the U.S. General Accounting Office (GAO).
- TILLINGHAST contends that insurance carriers frequently fail to make timely reports of malpractice payouts to the NPDB and that this failure may bias the 1996 data. However,

the GAO study of this problem does not demonstrate a systemic bias in NPDB data that would discredit trends in the number of malpractice claims and payouts.

**3) MEDICAL MUTUAL's own data supplied in TILLINGHAST's report reinforces PUBLIC CITIZEN'S key points that there is no liability insurance crisis in Maryland caused by lawsuits:**

- MEDICAL MUTUAL's *total medical malpractice payouts* (described in Fig. 9, TTP Report, p. 25) rose by \$6.0 million from 1994 through 2002, 12.2 percent overall or 1.5 percent a year. Adjusted for medical services inflation the total payouts actually *declined* \$8.9 million from 1994 through 2002, -18.2 percent overall or -2.3 percent a year. This trend is consistent with PUBLIC CITIZEN's finding for all Maryland insurer payouts. (Fig.1, P. C. Reply, p. 8)
- MEDICAL MUTUAL's *average medical malpractice payout* (described in Fig.10, TTP Report, p.26) rose by \$25,000 from 1994 through 2002, 10.4 percent overall or 1.3 percent a year. Adjusted for medical services inflation the average payout actually *declined* \$46,569 over the same period, -19.4 percent overall or -2.4 percent a year. This trend is consistent with PUBLIC CITIZEN's finding for all Maryland insurer payouts. (Fig. 2, P.C. Reply, p. 9)

See the Appendix for a more detailed discussion of Tillinghast's analytical limitations on insurance matters.

## Detailed Discussion of the Major Flaws in Tillinghast's Critique

### I. TILLINGHAST says using 1996 as a starting point causes comparisons to subsequent years to produce biased results.

- TILLINGHAST claims that the problem with using 1996 as the beginning point is: there was an unusually high number of claims filed in Maryland that year (TTP Report, p.12); there was an unusually high number of malpractice payouts in Maryland that year (TTP Report, p.11); in 1996 the mean (average) medical malpractice payout is significantly higher than for earlier years and appears to be an anomaly (TTP Report, p.13); and the total amount of malpractice payouts was unusually high in Maryland that year (TTP Report, p.14).
- TILLINGHAST speculates that artificially high number may have resulted from changes to Maryland's Health Claims Arbitration Act. Until October 1, 1995, all claims for medical malpractice had to be reviewed by an arbitration panel under the aegis of the Health Claims Arbitration Office.<sup>2</sup> The law formerly allowed a waiver of arbitration if agreed by all parties, but for claims after October 1, 1995, unilateral waiver is permitted. It is doubtful that this legal change explains the number of claims filed in 1996 for two reasons. First, well before 1995 a growing consensus had emerged among Maryland attorneys, both plaintiff and defense, that arbitration simply was not working and was adding unnecessary costs to processing a case. Second, the suspicion that attorneys held cases they planned to file until after the legal change was made in order to evade arbitration would result in a spike in filings in the last three months of 1995 rather than in 1996.
- TILLINGHAST claims that 1996 is an "unusually high point" in malpractice payments in Maryland. At another point TILLINGHAST refers to the "distorted 1996 data." (TTP Report, p.11-12) TILLINGHAST makes no effort to establish the validity of either characterization. Given its access to MEDICAL MUTUAL's claims information and considering that reports to the NPDB are made by the insurers, one would expect that it would have been relatively easy for TILLINGHAST to determine whether its suspicions concerning 1996 data, at least as far as MEDICAL MUTUAL was concerned, had any basis in fact.
- The increase in Maryland followed the national pattern and cannot properly be described as unusual. As reported by the National Practitioner Data Bank, malpractice payment reports increased across the nation by 10 percent from 1995 to 1996. Nationwide, there were 1,781 more malpractice payment reports received in 1996 than in 1995. Similarly, malpractice payments increased in Maryland by 12 percent from 1995 to 1996, from 206 to 230.

- Instead of accepting the NPDB numbers and attempting to get to the cause of the asserted anomalies, **TILLINGHAST** simply changed the numbers by averaging the 1995 and 1996 numbers. This represents a new variety of actuarial analysis. By this device, TILLINGHAST reduced the number of payouts in 1996 from 230 (the number reported by NPDB) to 218. (See Figure 1, TTP Report, p. 11) TILLINGHAST reduced the average payout in 1996 from \$310,100 (the amount reported by NPDB) to \$260,000. (See Figure 3, TTP Report, p. 14) TILLINGHAST reduced the total amount of malpractice payouts in 1996 from \$71.3 million (the amount reported by NPDB) to \$59 million. (See Figure 4, TTP Report, p. 15) This appears to be a case of TILLINGHAST changing the data to fit its preconceived notions of the truth.
- TILLINGHAST, apparently in an effort to further bolster MEDICAL MUTUAL's claims of a crisis, uses unverifiable payout data it says was taken from MEDICAL MUTUAL's files for the first nine months of 2003. Absent verification, how is the public to learn whether that brief time period represents a trend, as TILLINGHAST claims, or is simply an "aberration" – the charge Tillinghast leveled against Public Citizen's use of 1996 data.

## II. **TILLINGHAST criticizes PUBLIC CITIZEN's reliance on data from the National Practitioner Data Bank.**

- The NPDB, managed by the Department of Health and Human Services, is the most comprehensive source of information about *physician* medical malpractice claims and disciplinary actions. It is the only database that collects information on both physician malpractice claim payments and physician disciplinary proceedings. Insurers are subject to civil penalties for noncompliance. Malpractice payment reports must be submitted to the Data Bank within 30 days after an insurance company, such as Medical Mutual, or self-insured entity (but not a self-insured individual), makes a payment of any amount for the benefit of a physician, dentist, or other licensed health care practitioner in settlement of, or in satisfaction of, a judgment or malpractice action or claim.<sup>3</sup>
- The General Accounting Office in its August 2003 report, *Medical Malpractice, Implications of Rising Premiums on Access to Health Care*,<sup>4</sup> relied heavily on the NPDB to judge the growth in malpractice payments from 1996 through 2002. The GAO report says at page 4:

“To assess growth in malpractice claims payments, we analyzed state-level data on claims paid on behalf of all physicians reported by insurers to the National Practitioner Data Bank (NPDB) from 1996 through 2002 for all states and the District of Columbia.”

The GAO used precisely the same time frame, 1996 to 2002, as did PUBLIC CITIZEN. Although GAO acknowledged the limitations of the NPDB claims payment data, it concluded, on page 35:

“Nevertheless, because insurers must report payment of claims against physicians subject to federal law and not varying state laws, NPDB data are useful in comparing trends across states.”

- TILLINGHAST claims that one particular deficiency of relying on NPDB data is that it reflects claim information received during a particular 12-month period, and is subject to fluctuations in reporting. TILLINGHAST then points to the year-to-year fluctuations in Maryland malpractice payouts in the 1994 to 1998 period and gratuitously speculates that this may represent artifacts of the way claims are counted by year, rather than any real differences in claim counts. TILLINGHAST admits that “we do not know the source of the year to year fluctuations in Maryland counts in the mid 1990s,” but then arbitrarily resolves the fluctuation by averaging the 1995 and 1996 payouts to conveniently smooth out the reported differences. TILLINGHAST provides no actuarial reference supporting this statistical sleight-of-hand.
- TILLINGHAST also cites GAO’s November 2000 Report on the NPDB<sup>5</sup> to suggest that the failure of insurers to report malpractice payments on behalf of physicians within 30 days of the first payment as required by statute, may explain the increase in payouts reported for Maryland in 1996. However, a fair reading of that report does not support TILLINGHAST’s effort to discredit the overall trend in malpractice payments as reported by NPDB. GAO made an in-depth study of malpractice payment reports received by NPDB for the month of September 1999. The study revealed that about 25 percent (331) of the 1,300 malpractice reports received in that month were not submitted within the 30 days, as required. On average these reports were about 85 days late. The GAO report indicates that on-time reporting is an on-going problem, not one that is specific to the end of a particular year or month. It occurs throughout the year and, probably has been the case since reports were first required by the NPDB in 1990. As a result, GAO’s finding that some insurers fail to file their payment reports on time cannot be used as an excuse to discredit trends reported by the NPDB in the number of malpractice payments.

### **III. TILLINGHAST relies on information not capable of independent verification or that injects confusing and irrelevant comparisons.**

- TILLINGHAST provides several graphs and figures that it claims are based on data received from MEDICAL MUTUAL (see TTP Report, Figures 9 through 13). These figures purport to show MEDICAL MUTUAL’s total claims payouts, average indemnity paid, projected percent of claims with payment, profitability and ratio of investment income to assets. However, TILLINGHAST did not include or attach the data upon which the graphs are based as part of its report. As a result, there is no way to independently verify the claims made by TILLINGHAST.
- TILLINGHAST also cites data obtained from A.M. Best on medical malpractice payments in Maryland made by unnamed insurance companies. However, the payment data confuses the issue by including hospital, nursing home and dentist payments. As a result, it is not comparing doctor payments to doctor payments (see Figure 4, TTP Report, p. 15).

# **Detailed Rebuttal of Tillinghast's Critique of Public Citizen's Finding that There Is No Overall Medical Malpractice Lawsuit Problem in Maryland**

## **Patients and Consumers Suffer the Real Costs of Medical Malpractice**

- TILLINGHAST does not dispute that approximately 836 to 1,862 Maryland patients die every year in hospitals alone because of preventable medical errors. (P.C. Report, p.10)
- TILLINGHAST does not dispute that preventable medical errors in hospitals alone cost Maryland patients and consumers \$323 million to \$551 million each year based on 1999 figures. These figures have not been adjusted for inflation. (P.C. Report, p.10)
- TILLINGHAST does not dispute that total malpractice premium costs (for doctors, hospitals, and others) were \$155.1 million in 2001, an amount that is less than half the cost of preventable medical errors in Maryland hospitals in 2001. TILLINGHAST says the \$155.1 million figure is outdated and that the premium costs have gone up substantially since 2001. But the cost of preventable medical errors has also increased since 2001 and will continue to increase every year in the future.

## **Medical Malpractice Insurers Benefit from Declining Claims in Maryland**

- The number of medical malpractice lawsuits filed was 11.8 percent lower in 2002 than it was in 1996 according to the Maryland Office of Health Claims Arbitration. (P.C. Report, p.11) TILLINGHAST does not dispute this finding.
- Claims filed against Medical Mutual declined 11.5 percent from 1996 to 2001, from 506 claims in 1996 to 448 claims in 2001. (P.C. Report, p. 11) TILLINGHAST did not dispute this finding, which was in Medical Mutual's rate increase request made to the Maryland Insurance Administration in June 2003.
- The number of claims filed per physician has dropped 17.6 percent since 1996. (P.C. Report, p.12)
- In 1996, there were 3.4 legal claims for medical malpractice per 100 Maryland physicians, compared with 2.8 claims per 100 physicians in 2002. (P.C. Report, p.12)
- TILLINGHAST challenges these findings by suggesting, without convincing evidence, that more claims were filed in 1996 because of changes to the Health Arbitration Act. As discussed previously, this explanation is not reasonable.
- TILLINGHAST makes no effort to explain the inconsistency between its claims of a medical liability crisis and the fact that the number of malpractice claims filed in 2002 dropped nearly 10 percent from the number filed in 2001 (707 in 2001 vs. 637 in 2002). (P.C. Report, p.12)

## Number of Payouts for Medical Malpractice Has Remained Flat in Maryland

- According to the NPDB, in 1996 there were 230 medical malpractice payouts and in 2002 there were 266 payouts, an increase of 15.6 percent, or 2.6 percent a year. But, this slight increase all but disappears when the growing number of doctors in the state is considered. There were 1.2 malpractice payouts per 100 Maryland physicians in 2002, almost the same as the 1.1 ratio in 1996. (P.C. Report, p.14)
- TILLINGHAST does not dispute this figure but again claims that 1996 is an anomaly. It admits “we do not know” the reason for the year-to-year fluctuations in payouts reported (TTP Report, p. 11) and then simply changes (averages) the number of payouts to create an artificial increase of 20 percent between 1996 and 2002.

## Total Amount of Malpractice Payouts in Maryland Has Declined, When Adjusted for Medical Inflation

- Malpractice payouts totaled \$71.3 million in 1996 compared with payouts of \$73.6 million in 2002, an increase of \$2.3 million, or only 3.2 percent over six years. When adjusted for medical services inflation, malpractice payments declined 17.9 percent, from \$71.3 million in 1996 to \$58.5 million in 2002. (P.C. Report, p.15)
- TILLINGHAST, again, objects to use of “the distorted 1996 data” as the beginning year for the trend analysis in total payouts and, instead selects an earlier starting point and calculates the change from 1992 to 2002, which is claimed to demonstrate an increase in payouts beyond what would be expected based on medical services inflation. (TTP, p.14) Although convenient for TILLINGHAST’s purposes, this approach ignores the reality of what occurred in 1996 and the claims payment experience of Maryland insurers.
- But MEDICAL MUTUAL’s own data on *total medical malpractice payouts* (described in Fig. 9, TTP Report, p. 25) substantiates Public Citizen’s point. Medical Mutual’s payouts rose by \$6.0 million from 1994 through 2002: 12.2 percent overall or 1.5 percent a year. Adjusted for medical-services inflation, the total payouts actually *declined* \$8.9 million from 1994 through 2002: an 18.2 percent *decline* overall, or a 2.3 percent *decline* a year. This trend is consistent with PUBLIC CITIZEN’s finding for all Maryland insurer payouts.

**Figure 1**

**Total Medical Mutual Malpractice Claims Payouts,  
1994-2002 (Including Legal Expense)**

Year	Total Amount of Payouts	Year	Total Amount of Payouts
1994	\$49.0 million	1994	\$49.0 million
2002	\$55.0 million	2002	\$55.0 million
\$ Change (1994-2002)	\$6.0 million	\$ Change (1994-2002)	\$6.0 million
% Change (1994-2002)	12.2%	% Change (1994-2002)	12.2%

Source: Tillinghast-Towers Perrin, Medical Mutual Liability Insurance Society of Maryland, *Review of "The Facts about Medical Malpractice in Maryland" by Public Citizen*, Figure 9, p. 25; dollar figures are approximate.

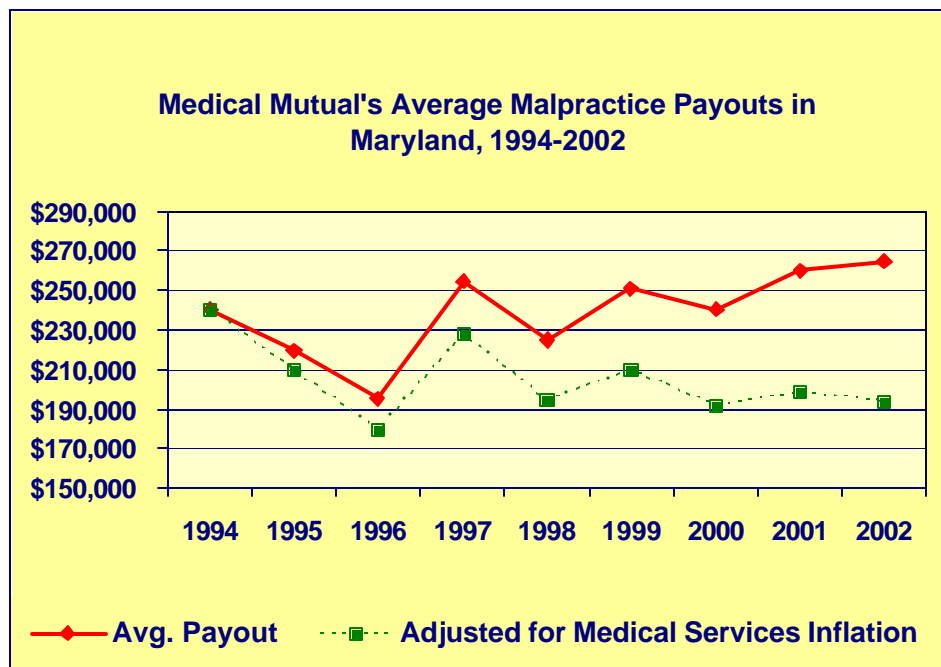
- TILLINGHAST says that trends in damage awards are not tied to trends in medical services inflation alone; suggesting that “changes in jury sentiment” might be the cause. (TTP, p. 16) But it produced no evidence that ordinary citizens have undergone transformations upon taking a juror’s oath, and it ignored other significant transformations that have occurred in our society that would add significantly to awards: increases in life expectancy and retirement age; increases in worker productivity and wages; increases in expectations of a healthy lifestyle; and a reduction in the rate of occupational injuries resulting in a healthier, safer society.
- Combined with medical inflation, these factors explain predictable increases in damage awards. In calling awards “excessive,” MEDICAL MUTUAL would exile injured patients to a time warp, when our society was less affluent, less safe, and less healthy. The only appropriate response to rising damage awards is to recognize that the lives and health of patients are substantially more valuable than they were a decade ago. Corporate America made this recognition in launching the Leapfrog Project, a program to reduce medical errors that have caused businesses to lose valued employees. Just as an antique vase must be handled with more care than a plastic knick-knack, patients need to be treated with greater care in the 21<sup>st</sup> Century.

**The Mean Malpractice Payouts in Maryland Have Declined Substantially**

- NPDB data on payouts made to injured patients shows that the mean payout in 1996 was \$310,000, compared with a mean of \$276,842 in 2002, a drop of \$33,258 or 10.7 percent. (P.C. Report, p.16)

- Adjusted for the cost of medical services, the mean payout declined to \$220,083, a drop of 29 percent from 1996. (P.C. Report, p. 16-17)
- TILLINGHAST concedes that PUBLIC CITIZEN “accurately” charts the decline in mean medical malpractice payments reported by NPDB, nevertheless, TILLINGHAST again contends that 1996 represents “an anomaly.” Unfortunately, TILLINGHAST offers no basis for its belief other than the fact that the average payout in 1996 was more than in previous years.
- MEDICAL MUTUAL’s *average (mean) medical malpractice payout* (described in Fig.10, TTP Report, p.26) rose by \$25,000 from 1994 through 2002: 10.4 percent overall, or 1.3 percent a year. Adjusted for medical-services inflation, the average payout actually *declined* \$46,569 over the same period: a 19.4 percent *decline* overall, or a 2.4 percent *decline* a year. This trend is consistent with PUBLIC CITIZEN’s finding for all Maryland insurer payouts.

**Figure 2**



Source: Tillinghast-Towers Perrin, Medical Mutual Liability Insurance Society of Maryland, *Review of “The Facts about Medical Malpractice in Maryland” by Public Citizen*, Figure 10, p. 26; dollar figures are approximate.

### Million Dollar Payments Are an Unusual Occurrence in Maryland

- NPDB data demonstrates that million dollar payments on behalf of physicians have been an unusual occurrence in Maryland. From 1996 through 2002 there have been only 33

malpractice payments of a million dollars or more out of 1,637 payments. (P.C. Report, p.14) There were only three such payouts reported in both 2001 and 2002, compared to eight in 1996 and 2000. (P.C. Report, p.17)

- TILLINGHAST reports that MEDICAL MUTUAL has seen an increase in million dollar payouts in 2003. To support this assertion it relies on MEDICAL MUTUAL data not included in its report and apparently provided only to TILLINGHAST.
- If MEDICAL MUTUAL has, in fact, seen an increase in the number of payouts exceeding one million dollars it would be interesting to analyze the breakdown of those payments. Were they judgments or settlements? What portion were economic damages rather than non-economic damages? Do the awards consist primarily of compensation for the expense of a life-time of medical care? Do the awards represent compensation for loss of significant earnings? Specifically, what impact, if any, would further reductions in Maryland's cap on non-economic damages have on these payouts other than depriving seriously injured victims of fair compensation?
- TILLINGHAST implies, without proof that MEDICAL MUTUAL's growth in million dollar claims is caused by the civil justice system. But as has been noted in books such as "The Millionaire Next Door," there has been substantial growth in the number of affluent households in the U.S., making such awards inevitable. According to a study by the Tower Group consulting firm, "From pre-1999 through 2000, the number of millionaires in the U.S. was rising at a compound annual growth rate of 18 percent."<sup>6</sup>

### **There Is No Evidence of a Doctor Exodus**

- TILLINGHAST does not dispute the fact that the number of doctors in Maryland increased from 20,994 in 1996 to 22,559 in 2002, an increase of 7.4 percent. (P.C. Report, p. 18)
- TILLINGHAST does not dispute the fact that Maryland has the fourth highest ratio of doctors-to-population among all 50 states and the District of Columbia. (P.C. Report, p. 18)
- TILLINGHAST does not present any data to support the claim that Maryland has a shortage of physicians.

### **Three Percent of Maryland Doctors Are Responsible for Half of the Medical Malpractice Payouts in Maryland**

- According to NPDB data, 3 percent of Maryland doctors are responsible for 51 percent of the total number of malpractice payouts to Maryland patients from Sept. 1, 1990 to Dec. 31, 2002. Each of these doctors made at least two malpractice payouts. (P.C. Report, p. 19)

- 1 percent of Maryland doctors have made 24 percent of medical malpractice payouts. Each of these doctors made at least three payments. (P.C., p. 19)
- 89 percent of Maryland doctors have never made a malpractice payout. (P.C., p. 19)
- TILLINGHAST does not dispute the accuracy of these figures but counters that medical malpractice is a line of insurance characterized by large claims. Those physicians who happen to have the large claims will account for a large share of the total payouts. (TTP Report, p.17) TILLINGHAST misses PUBLIC CITIZEN's point entirely, which is that a small *number* of doctors have a disproportionately large *number* of the malpractice payouts. That fact has nothing to do with the *size* of the payment.
- TILLINGHAST argues that the concentration of malpractice in repeat offender doctors (3 percent of doctors make 51 percent of malpractice payments) could be “based on chance alone without any clustering of claims among bad physicians.” (TTP Report, p. 18) Yet TILLINGHAST also says that MEDICAL MUTUAL payments on behalf of such doctors “are lower yet, reflecting the company’s aggressive underwriting and experience rating program.” This only begs the question: If it’s possible for insurance underwriters to identify questionable doctors for premium purposes, why can’t those responsible for disciplining doctors act to remove them from patient care? Underwriting practices remove bad doctors from one company’s risk pool, often shifting them to other insurers, but stronger disciplining of dangerous doctors would remove them from the risk pool as a whole, *and* provide protection to patients from medical negligence and errors.

### **Doctors with Repeated Malpractice Claims Against Them Suffer Few Consequences**

- TILLINGHAST does not dispute the fact that the Maryland Board of Physician Quality Assurance (renamed the Maryland Board of Physicians) has been criticized in the media and by lawmakers for failing to rein in doctors who repeatedly commit medical errors and medical negligence.
- TILLINGHAST does not dispute the fact that according to PUBLIC CITIZEN's analysis of Maryland's NPDB data, only 20.6 percent of Maryland doctors who have made at least three malpractice payouts have been disciplined, or that doctors can make up to 10 malpractice payouts before the odds of some disciplinary action being taken against them reaches 50 percent. (P.C. Report, p. 20)
- TILLINGHAST claims that licensure actions reported in NPDB data are not necessarily complete and cite without explanation the GAO report, *National Practitioner Data Bank: Major Improvements Are Needed to Enhance Data Bank's Reliability*, from November 2000. A review of that report reveals that Health Resources and Services Administration officials acknowledge that “the states report licensure actions, as required.” (p. 13) The criticism GAO had for the reporting of state licensure actions, after studying 252 filed in September 1999, was that the reports could confuse or mislead querying organizations about the severity of the sanctions imposed, not whether licensure actions had occurred.

- TILLINGHAST does not dispute the fact that in 2002, Maryland ranked 46<sup>th</sup> among all states and the District of Columbia for the frequency at which it takes serious disciplinary actions against doctors for incompetence, misprescribing drugs, sexual misconduct, criminal convictions, ethical lapses or other offenses. (P.C. Report, p. 21) This finding is based on information supplied directly by disciplining bodies throughout the country and is fully reported on PUBLIC CITIZEN's Website at [www.questionabledoctors.org/](http://www.questionabledoctors.org/).

### **Congressional Watchdog Agency Finds Claim of Malpractice Insurance “Crisis” Unsubstantiated**

- GAO's study, *Medical Malpractice: Implications of Rising Premiums on Access to Health Care*, from August 2003, of five states claimed to be in a medical malpractice “crisis” by the American Medical Association failed to reveal convincing evidence that increased premium costs had caused a significant number of physicians to move or close practices, reduced high-risk services, or altered their practices to include so-called defensive medicine.
- In fact, GAO determined that many of the reported provider actions were not substantiated or did not affect access to health care on a widespread basis based on its review of Medicare data and contacts with providers that have reportedly been affected. (GAO Report, p.2)
- The AMA's claim that health care costs are driven up by the widespread practice of defensive medicine also could not reliably be measured, according to the GAO. (GAO Report, p.2)
- TILLINGHAST acknowledges GAO's findings that access to care has not been widely affected; that some reports of physicians moving, retiring or closing practice proved to be inaccurate or affected only small numbers of physicians; and that there was not adequate information available to establish the scope of defensive medicine. However, TILLINGHAST bristled at PUBLIC CITIZEN's conclusion that these GAO findings unmasked efforts by the AMA and its affiliates, such as Maryland's Med Chi, to spread misinformation and unsubstantiated claims in order to create a sense of “crisis” in selected states. However, that is precisely what PUBLIC CITIZEN intended.

### **Rather than Facing “Runaway Litigation,” Doctors Benefit from a Claims Gap**

- TILLINGHAST does not dispute that a landmark Harvard Medical Practice Study found that only one in 7.6 instances of medical negligence committed in hospitals results in a malpractice claim. (P.C. Report, p. 24)
- TILLINGHAST does not dispute that other government sources also show that a very small percentage of people injured by medical negligence actually file claims. (P.C. Report, p. 24-25)

- TILLINGHAST does not dispute that according to the Medicare Payment Advisory Commission, Maryland physicians spend only 2.4 to 2.9 percent of practice incomes on malpractice insurance costs, compared with a national average of 3.2 percent. (P.C. Report, p. 13)
- TILLINGHAST does not dispute that total expenditures on medical liability comprise less than one percent of overall health costs. (P.C. Report, p.24)
- Medical malpractice liability costs make up only a tiny fraction of total health care costs. According to a study by the Consumer Federation of America, medical malpractice costs, as a percentage of health care costs, are at an all time low, 0.55 percent.<sup>7</sup> In other words, less than one penny of every dollar spent annually in this country for health care goes to pay all of the annual medical malpractice settlements, verdicts, defense costs, attorney fees, as well as insurance company overhead and profits.

### **Empirical Evidence Does not Confirm the Existence of “Defensive Medicine”– Patient Injuries Refute It**

- Tillinghast does not rebut Public Citizen’s lengthy analysis that there is no empirical evidence that doctors are practicing “defensive” medicine. (P.C. Report, pp. 28-30)

### **Few Malpractice Lawsuits Are “Frivolous”**

- Tillinghast suggested that a substantial share of malpractice claims are “without merit” because “a little over 70% of claims were closed without indemnity payment.” (TTP Report, p. 22)
- TILLINGHAST does not dispute or discuss any of the reasons underlying the low success rate of malpractice claims and, in fact, TILLINGHAST presents data it says it obtained from MEDICAL MUTUAL that indicates that the “proportion of claims on which an indemnity payment is made has increased as shown in Figure 11.” According to Figure 11 the percent of claims closed with a payment increased from 22 percent in 1997 to 32 percent in 2001. (TTP Report, p.27)
- **Many factors contribute to the low success rate of medical malpractice claims.**
  - **Many claims are closed after initial review.** Attorneys ethically are required to investigate the merits of their client’s claims and in order to do so will request copies of the client’s medical records from the appropriate providers. Upon receipt of a request for records or other notice of potential claims from their insureds, the insurance company may open a claims file. If the claim is not pursued, because, for example, further investigation shows it’s without merit, the file will be closed and added to the list of claims closed without payment.

- **Relevant medical information is controlled by the medical providers.** In virtually every case all of the pertinent information concerning what happened and why is within the control of the care providers and the providers rarely candidly discuss what went wrong with the victims or their families. All medical malpractice cases require the support of qualified medical experts and claimants' access to expert testimony is much more limited than that of the defendants. It is common for defendants to present the testimony of two or three experts for every one expert called by the claimant.
- **Financial self-interest deters attorneys from pursuing claims without merit.** Victim's attorneys are invariably paid via a contingency fee agreement. This means, the attorney receives payment only in the event the claim is closed with a payment. Usually the agreement provides that the attorney will receive a percentage of the net recovery. 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 trivial, flimsy or unimportant case. This is not to say that from time to time an attorney will file a claim that later turns out to be flimsy. However, an attorney cannot afford to have many flimsy cases or he will soon be looking for a different line of work.

## Detailed Discussion that Reforms Are Needed to Reduce Medical Errors and Insurance Rates

### Caps on Damages Are a False “Solution”

- TILLINGHAST does not guarantee that caps on non-economic damages will reduce premiums, instead it provides a variety of excuses why companies are reluctant to reduce rates after “tort reform” (court challenges, cap may be too high, reinsurer costs, etc.). However, TILLINGHAST failed to provide any information challenging PUBLIC CITIZEN’s claim that the number of cases where caps will reduce the amount paid to severely injured victims comprises only a small percentage of medical malpractice claims and therefore will have little or no effect on rates.
- TILLINGHAST does not dispute that non-economic damages are an important part of the compensation for those seriously injured by medical negligence. (P.C. Report, p. 47)
- TILLINGHAST does not dispute that limits on non-economic damages have a disproportionately adverse impact on children, women, seniors and minorities. (P.C. Report, p. 47)
- TILLINGHAST does believe that limits on non-economic damages *may* eventually reduce claim costs for physicians and their insurers, two groups whose financial needs apparently trump those who have been negligently injured. (TTP Report, p.36)
- TILLINGHAST does not dispute that studies in California, Florida, North Carolina, New York and Ohio and the industry’s own statistics demonstrate that jury verdicts bear a reasonable relationship to the severity of the harm suffered and are not random “jackpots.” (P.C. Report, p. 47)

### Insurance Companies and Their Lobbyists Admit Caps on Damages Won’t Lower Insurance Premiums

- Insurance companies and their lobbyists recognize there’s no guarantee that a cap on non-economic damages will lead to lower premiums for doctors. TILLINGHAST did not dispute any of the dozen or so statements from prominent insurance experts quoted in PUBLIC CITIZEN’s report. (P.C. Report, p. 48-49)
- Since PUBLIC CITIZEN’s report, Leo Jordan, retired vice president and counsel for Illinois-based State Farm Insurance Companies and past chair of ABA’s Tort Trial and Insurance Practice Section has said: “There’s a real question as to whether a cap on damages has a relationship to premiums....There doesn’t seem to be a lot of evidence that supports a correlation between caps and premiums.”<sup>8</sup>

- TILLINGHAST places heavy emphasis on the \$250,000 cap on non-economic damages adopted by California in 1975 under MICRA (Medical Injury Compensation Reform Act) and points to a comparison of California premiums as a percentage of countrywide malpractice premiums showing a decline beginning in 1985. The delay, according to TILLINGHAST, can be explained by the fact that the cap was not ruled constitutional until 1985.
- TILLINGHAST has conveniently ignored significant facts about what really happened in California.

### The Truth About What Really Happened in California Following the Enactment of MICRA (Medical Injury Compensation Reform Act)

- **In the first twelve years of MICRA in California (1976 to 1988) medical malpractice premiums increased 190 percent.** In 1976, the first year of MICRA the total premiums earned by California medical malpractice insurers were \$228 million. Twelve years later, 1988, the total premiums earned had skyrocketed to \$663 million per year.<sup>9</sup>
- **Initially insurers argued that questions concerning the constitutionality of MICRA prevented the lowering of premiums.** However, MICRA’s constitutionality was upheld in State Supreme Court decisions handed down in 1984 (periodic payments and collateral source provisions upheld) and 1985 (damage cap upheld). Nevertheless, premiums earned saw their largest jump in 1986 than in any year since the adoption of MICRA.

<u>Year</u>	<u>CA Prem. Earned</u>	<u>Percentage Change</u>
1983	\$287 million	36.4%
1984	\$374 million	30.4%
1985	\$449 million	20.0%
1986	\$629 million	40.0%

- **Passage of Prop 103 in 1988 finally lowered medical malpractice rates.** 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.<sup>10</sup>
- **Within three years of passage of Prop 103, medical malpractice premiums dropped 20 percent.** After adjusting for inflation (using the CPI-All Urban Consumers), the premium drop was 30.7%.

<u>Year</u>	<u>Premiums Earned</u>	<u>% Change</u>	<u>Cumulative Change</u>
1988	\$663 million	----	----
1989	\$633 million	-4.5%	-4.5%
1990	\$605 million	-4.4%	-8.7%
1991	\$529 million	-12.7%	-20.2%

- **After adoption of Prop 103, medical malpractice rates fell dramatically in the first years as a result of the proposition’s mandates, and thereafter have generally followed the rate of inflation. Since 1988 total premiums earned have declined from \$663 million to \$647 million in 2001, not accounting for inflation.**

<u>Year</u>	<u>Percentage Change</u>	<u>Year</u>	<u>Percentage Change</u>
1992	-0.5%	1997	+3.1%
1993	+6.9%	1998	+3.8%
1994	+2.5%	1999	-6.3%
1995	+3.6%	2000	-0.3%
1996	+2.1%	2001	-0.3%

- **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.
- **Prop 103 promoted full democratic accountability to the public in the implementation of the initiative by making the Insurance Commissioner an elected position.**
- **Major California malpractice insurers refunded a total of \$153 million to California doctors as a result of the 20 percent rollback mandated by Prop 103.** Prop 103 provided an opportunity for insurers to demonstrate that their rates had not been excessive, and that they could not afford to pay a rate rollback. Rather than open their books and prove those claims the refunds were paid after the insurers had lost all court challenges to the validity of Prop 103.
- **Prop 103 authorized consumers to challenge insurance companies’ rates or practices in court or before the Department of Insurance.**

## **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 Proposition 103, which has held down medical malpractice and other insurers' rates since the initiative was approved in 1988 by creating a "prior approval" regulatory system that requires insurers to justify rates to the insurance commissioner and allows consumers to challenge excessive rates.

## Appendix

TILLINGHAST is a consulting firm that is no doubt capable of providing its clients with objective and accurate actuarial advice. However, its forays into critiquing the civil justice system have not met that standard. Recently, the Congressional Budget Office (CBO) strongly criticized the methodology of TILLINGHAST's report on the *Costs of the U.S. Tort System*, in which it mischaracterized compensation as "costs."<sup>11</sup> The result was that TILLINGHAST inflated by nearly double its sensational \$205 billion cost estimate for the tort system, providing the raw material for a misleading public relations campaign on a so-called "tort tax."

TILLINGHAST's methodology was flawed in three ways:

- 46 percent of the "costs" are for payments made to injured plaintiffs for lost wages, medical care, and pain and suffering. These costs are the result of injuries caused by defendants and would be borne by society anyway either through government programs, charities or absorbed by the victims and their families and friends. The CBO said that these "transfer payments" to compensate victims are not in fact "costs" because they "do not involve any use of resources to produce goods or services."
- 35 percent of the total tort cost study's puffed-up cost estimate is for insurance industry overhead (21 percent) and defense costs (14 percent). Much of this insurance overhead would exist anyway because it is unrelated to lawsuits (setting rates, administering policies, marketing, profit taking, etc.) or is a result of negligence by insurance companies' clients.
- TILLINGHAST acknowledges that the tort system provides indirect benefits to society that is not measured in the study. These include acting as a deterrent to unsafe practices and products. While we don't encourage a monetaristic view of this issue, it's quite likely that the benefits of lawsuits – in terms of forcing changes to defective products and making professionals alter their harmful actions – result in much larger savings (in terms of lives saved and injuries prevented) than the tort system costs. This prevention argument is best illustrated by a recent study by the Bush White House examining the costs and benefits of 107 federal regulations – primarily health, safety and environmental protections – covering a 10-year period. The analysis found that: "The estimated total annual quantified benefits of these rules range from \$146 billion to \$230 billion, while the estimated total annual quantified costs range from \$36 billion to \$42 billion."<sup>12</sup>

## Endnotes

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<sup>1</sup> Notes from the Chair of the Board, newsletter of Medical Mutual Liability Insurance Society of Maryland, October 2002.

<sup>2</sup> Md. Code Ann., Cts. & Jud. Proc. § 3-2A-02 (1995).

<sup>3</sup> 42 U.S.C. Sec. 11131 (2000).

<sup>4</sup> United States General Accounting Office, *Medical Malpractice: Implications of Rising Premiums on Access to Health Care*, August 2003, GAO-03-836.

<sup>5</sup> U.S. General Accounting Office, *National Practitioner Data Bank: Major Improvements Are Needed to Enhance Data Bank's Reliability*, November 2000.

<sup>6</sup> TowerGroup Press Release, "While Wealth Management Opportunity Remains Strong, Promise of Technology Stymied by Financial Institution 'Silos'." September 16, 2003.

<sup>7</sup> Center for Justice and Democracy, "Mythbuster: 10 Things you should know about medical malpractice," 2002.

<sup>8</sup> Leo Jordan, Chicago Lawyer, November, 2003.

<sup>9</sup> All of the information in this section is taken from the Testimony of Harvey Rosenfield, The Foundation for Taxpayer and Consumer Rights', Before the House Energy and Commerce Committee, Subcommittee on Health, February 27, 2003.

<sup>10</sup> Ibid.

<sup>11</sup> Congressional Budget Office, "The Economics of U.S. Tort Liability: A Primer," October 2003.

<sup>12</sup> *Informing Regulatory Decisions: 2003 Report to Congress on the Costs and Benefits of Federal Regulations and Unfunded Mandates on State, Local and Tribal Entities*, Office of Management and Budget, Office of Information and Regulatory Affairs, September 22, 2003, p. 3.