# The Facts About
# Medical Malpractice in Kentucky


**Congress Watch**
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## Acknowledgments

The principal authors of "The Facts About Medical Malpractice in Kentucky" were Public Citizen's Congress Watch Research Director Neal Pattison, working in collaboration with Congress Watch Director Frank Clemente and Legislative Counsel Jackson Williams. Significant research contributions were made by Special Counsel Barry Boughton and Senior Researcher Taylor Lincoln.

## About Public Citizen

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# The Facts About Medical Malpractice in Kentucky

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# Executive Summary

The American Medical Association (AMA) last year declared Kentucky to be a "crisis" state when it comes to the malpractice liability system. Matching the AMA's alarmist tone, the Kentucky Medical Association has issued warnings about a "state of continuous crisis," which it says threatens to limit patient access to care.

It is understandable that doctors are concerned by increases in medical malpractice insurance costs. Nobody wants to see physicians forced to pay more to insure themselves, even if they are highly paid specialists who earn hundreds of thousands of dollars a year. It is essential, however, that discussions of public policy and attempts to address the issue of medical liability insurance be based on solid facts, not a false sense of "crisis" generated to serve special interests.

The strident tone used to discuss medical malpractice in Kentucky mirrors comments made on the national level, including claims by President Bush that "junk and frivolous lawsuits" have become "one of the major cost drivers in the delivery of health care." (In fact, the Congressional Budget Office reports that costs associated with medical malpractice insurance represent less than 2 percent of the nation's health care costs.)

Like the AMA and many state medical associations – including the Kentucky Medical Association – the president advocates a $250,000 cap on the amount that injured patients can receive for a lifetime of pain and suffering – known as non-economic damages.

In seeking to limit the legal rights of injured patients, physician groups and their political allies are essentially blaming those patients and their lawyers for the temporary spike in some insurance premiums.

While proponents of such legislation argue that litigation and payouts have caused a spike in malpractice insurance premiums – and while they suggest that insurance costs are forcing doctors out of business – this report demonstrates that these claims are not supported by reliable data.

The real long-term threat to the quality of health care of Kentucky residents is the unfortunate number of preventable medical errors that are made by a small minority of the state's doctors. Rather than working to limit patient rights, the vast majority of competent, conscientious doctors could join in efforts to reduce medical mistakes and improve physician oversight in Kentucky.

This Public Citizen study, which relies on statistics from numerous government agencies and other reputable sources, has two principal findings:

1) There is no overall medical malpractice lawsuit problem in Kentucky – the median payouts to injured patients are down significantly, the amounts health care providers pay for malpractice insurance have risen slower than inflation and there is no evidence of a doctor exodus.

2) The bigger health problem in Kentucky is the considerable amount of medical malpractice that is committed by a small number of the state's doctors, many of whom go undisciplined.

Other findings, based on government statistics and other reliable sources, include:

- **Patients and consumers suffer the real costs of medical malpractice.** The true impact of medical malpractice in Kentucky should be measured by the cost to patients and consumers, not the premiums paid by doctors and other health care providers to insurance companies. Extrapolating from the Institute of Medicine findings, we estimate that there are at least 632 to 1,407 preventable deaths in Kentucky hospitals each year that are due to preventable medical errors. The costs resulting from preventable medical errors to Kentucky's residents, families and communities is estimated at $244 million to $416 million each year. But the cost of medical malpractice insurance to Kentucky's health care providers is only $81.8 million a year.

- **The amount of malpractice payouts in Kentucky *declined* 4.1 percent from 1995-2002, when adjusted for inflation.** According to the federal National Practitioner Data Bank (NPDB), Kentucky malpractice payouts increased 24.2 percent from 1995 to 2002, or 3.5 percent annually, while the cost of medical services increased 30.5 percent, or 4.4 percent annually during these seven years. When measured in 1995 dollars, total malpractice payouts to injured patients in Kentucky *declined* from $38.5 million in 1995 to $36.9 million in 2002.

- **Kentucky's median malpractice payout in 2002 was only half what it was in 1995.** In 1995, the median malpractice payout in Kentucky was $92,500, according to the NPDB. By 2002, the Kentucky median had declined to $47,500 – a *drop* of 48.6 percent. The 2002 median payout for Kentucky was significantly lower than for preceding years, reflecting the unusual record of a single physician who made 76 payouts totaling $947,500. If payouts by this one physician were eliminated from the 2002 totals, Kentucky's median payout would have been $97,500 – still only a 5.4 percent increase since 1995 at a time when medical inflation rose 30.5 percent.

- **Million-dollar malpractice payouts have been infrequent in Kentucky.** There were five payouts exceeding $1 million in 2002, compared with six such payouts in 1995, according to the NPDB. The average number of payouts of $1 million or more during the past seven years has been just 3.2 annually.

- **Cost of malpractice insurance to Kentucky health care providers has declined slightly.** Measured in 1995 dollars, health care providers paid $62.9 million for malpractice coverage in 2002, compared with $63.4 million in 1995, according to the National Association of Insurance Commissioners. This represents a 0.8 percent *decrease*. During these seven years, the cost of malpractice premiums increased 29 percent – from $63.4 million to $81.8 million – or 4.1 percent annually. During this same period, costs of medical services increased 30 percent – or 4.3 percent annually.

- **Malpractice insurance costs comprise a small percentage of physician expenses.** According to the federal government's Medicare program, doctors spend nationally an average of 63.4 percent of their practice incomes on their own salaries, 33.4 percent on such overhead as office payroll and rent, and only 3.2 percent of their practice incomes on malpractice insurance. And Kentucky doctors spend an average of only 2.8 percent of their practice incomes on malpractice insurance – 12.5 percent less than the national average.

- **Claims about doctors abandoning Kentucky are contradicted by official data.** The Kentucky Medical Association has publicly claimed that Kentucky lost 819 practicing doctors during the two years ending in 2002. Official demographic statistics compiled by the Kentucky Board of Medical Licensure show that there were 8,911 licensed physicians working in Kentucky in 2000, and 8,892 physicians in 2002 – a difference of only 19 doctors. Furthermore, there was a decrease of 214 doctors in the populated counties of Jefferson and Fayette during those two years – indicating the small decline occurred in urban areas, not in rural areas where access to doctors is a more critical issue.

- **The ratio of doctors to residents has increased faster in Kentucky than in neighboring states.** From 1985 to 2001, the ratio of physicians per 1,000 Kentucky residents rose from 1.62 to 2.33 – a 43.8 percent growth in this measurement of the prevalence of doctors. In comparison, during the same period this measurement increased at a slower rate in four neighboring states of Indiana, Missouri, Ohio and Tennessee, some of which had caps on melpractice awards in place during this time.

- **Five percent of doctors are responsible for half of Kentucky's medical malpractice payouts.** According to the federal government's National Practitioner Data Bank, just 4.7 percent of Kentucky's doctors have been responsible for 49.9 percent of all malpractice payouts to patients. Overall, these 411 doctors, all of whom have made two or more payouts, have paid $171.9 million in damages since 1990. Even more surprising, just 1.6 percent of Kentucky doctors (141), each of whom has paid three or more malpractice claims, were responsible for 26.7 percent of all payouts.

- **The vast majority of doctors have no record of malpractice payouts.** In Kentucky, 83.3 percent of doctors have not made a medical malpractice payout since September 1990, when the NPDB was created.

- **Doctors with repeated malpractice claims against them suffer few consequences**. Only 9.9 percent of Kentucky doctors who made two or more malpractice payouts were disciplined by the Kentucky Board of Medical Licensure, according to the NPDB. Only 12 percent of doctors who made three or more malpractice payouts were disciplined. And only 20 percent who made four or more malpractice payouts were disciplined.

- **A cap of $250,000 on non-economic awards would have affected about 8.4 percent or fewer of the malpractice payouts made in Kentucky during 2002.** In medical malpractice payouts, it is unusual for non-economic damages to comprise more than

one-third to one-half of the total payout. Of 261 payouts reported to the NPDB from Kentucky for 2002, only 22 – or 8.4 percent – were more than $500,000 in combined economic and non-economic damages (likely to be affected by a $250,000 non-economic cap). And only 15 payouts – 5.7 percent – were for more than $700,000 in combined economic and non-economic damages (likely to be affected by a $350,000 non-economic cap). Such a small universe of cases make it unlikely even a draconian cap of $250,000 would affect insurance rates.

- **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). The safety effort proved superior to damage caps in holding down awards. For example, during the 1990s, the median malpractice award in California, which has stringent caps, increased by 103 percent, but the median anesthesiology malpractice award remained constant.

- **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" and found that the AMA's claims that medical services were unavailable in particular areas because of malpractice costs were not reliable; and claims that the overall number of doctors in the "crisis" states had declined were based on questionable surveys. Claims of a "crisis" by Kentucky doctors should be held to the same standard of evaluation that the GAO applied to other states.

- **Medical liability premium spikes are caused by the insurance cycle and mismanagement, not the legal system.** For much of the 1990s, doctors benefited from artificially lower premiums. According to the International Risk Management Institute (IRMI), insurers were on a quest for market share – "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."

- **Medical liability premiums track investment results.** An analysis by J. Robert Hunter of the Consumer Federation of America found that rates for medical malpractice insurance premiums 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; when the economy falters and interest rates fall, companies increase premiums in response.

- **Action could be taken on a national level to reduce medical errors.** The only way to reduce the cost of medical injuries is to reduce negligence and mistakes – and the best way to accomplish this is by reforming the regulatory oversight of the medical profession. Public Citizen recommends opening up the National Practitioner Data Bank to empower consumers with information about doctors who have made multiple malpractice payouts. Public Citizen also recommends implementing the "systems approach" advocated by the Institute of Medicine to establish mandatory nationwide error reporting systems, identify unsafe practices and raise performance standards. And Public Citizen recommends that Congress encourage better oversight of physicians through grants to state medical boards, tied to the boards' agreements to meet performance standards.

- **States should improve oversight of health-care providers.** When negligent doctors are disciplined, it is rarely for inferior care. Instead, state medical boards frequently respond to more easily documented things such as prescription drug violations, fraud convictions or disciplinary actions taken in other states. Governance of physicians would improve if medical and licensing boards were required to sever formal links with state medical societies. And legislatures could help ensure that medical boards have enough revenue to hire more investigators and legal staff to perform effective oversight.

- **State regulators could make insurance rates more predictable.** J. Robert Hunter, Director of Insurance for the Consumer Federation of American, on behalf of Americans for Insurance Reform, has recommended a number of steps to state insurance regulators. These include thoroughly auditing insurance companies' pricing and profitability data; regulating excessive prices; freezing "stressed rates" until prices and jumps in loss reserves can be analyzed; and requiring medical malpractice insurers to use claims history as a rating factor. Hunter also advocates creating a standby public insurer to write risks during "hard markets," and asking the National Association of Insurance Commissioners to stop the implementation of the deregulation of commercial rates and forms, which it is unwisely pushing.

# Patients & Consumers Suffer the Real Costs of Medical Malpractice

In 1999, the Institute of Medicine (IOM) estimated that from 44,000 to 98,000 Americans die in hospitals every year from *preventable* medical errors.[1] 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 Kentucky should be measured by the cost to patients and consumers, not the premiums paid by doctors and other health care providers to their insurance companies. Extrapolating from the IOM findings, we estimate that there are at least 632 to 1,407 preventable deaths in Kentucky each year that are due to preventable medical errors. The costs resulting from preventable medical errors to Kentucky's residents, families and communities is estimated at $244 million to $416 million each year. But the cost of medical malpractice insurance to Kentucky's health care providers is only $81.8 million a year.[2] [See Figure 1]

## Figure 1

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

**632 - 1,407**
**Preventable Deaths Due to Medical Errors Each Year**

**$244 million - $416 million**
**Costs Resulting from Preventable Medical Errors Each Year**

**$81.8 million**
**Cost of Kentucky Health Care Providers' Annual Medical Malpractice Premiums**

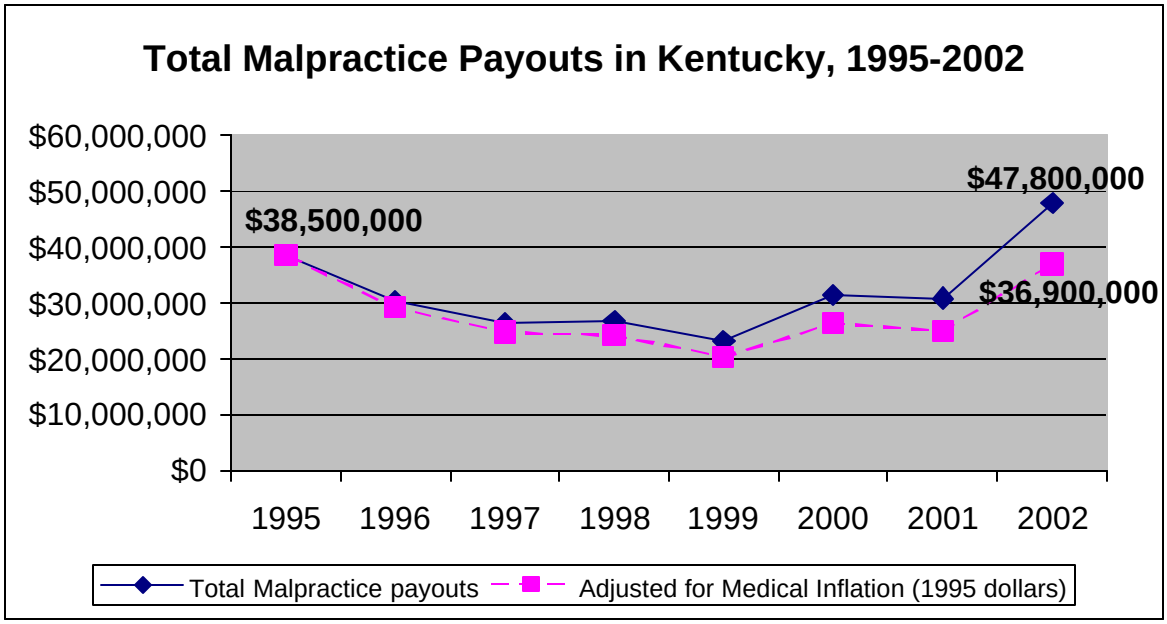
*Sources:* Preventable deaths and costs are prorated based on population and based on estimates in *To Err Is Human*, Institute of Medicine, November 2000. Malpractice premiums are based on "Medical Malpractice Net Premium and Incurred Loss Summary," National Association of Insurance Commissioners, July 18, 2002.

# Total Medical Malpractice Payouts Have Declined in Kentucky When Adjusted for Inflation

Physicians and their political allies have made gloomy pronouncements suggesting that a "continuous crisis" in medical malpractice insurance costs is squeezing Kentucky physicians out of business.[3] In fact, statistics from the federal National Practitioner Data Bank show that annual amounts paid out by health care providers to injured patients have decreased slightly when medical inflation is taken into account. This is significant, since one half to one third of malpractice payouts customarily go toward covering medical expenses, which can be expected to rise along with the cost of medical services.[4]

- **The amount of malpractice payouts in Kentucky *declined* 4.1 percent from 1995-2002, when adjusted for inflation.** Kentucky malpractice payouts increased 24.2 percent from 1995 to 2002, or 3.5 percent annually, while the cost of medical services increased 30.5 percent, or 4.4 percent annually during these seven years. When measured in 1995 dollars, total malpractice payouts to injured patients in Kentucky *declined* from $38.5 million in 1995 to $36.9 million in 2002 – a 4.1 percent drop. [See Figure 2]

## Figure 2




*Sources:* National Practitioner Data Bank, Jan. 1, 1995 – Dec. 31, 2002; Bureau of Labor Statistics – Medical Services CPI.

# Median Malpractice Payouts in Kentucky Have Declined by 50 Percent

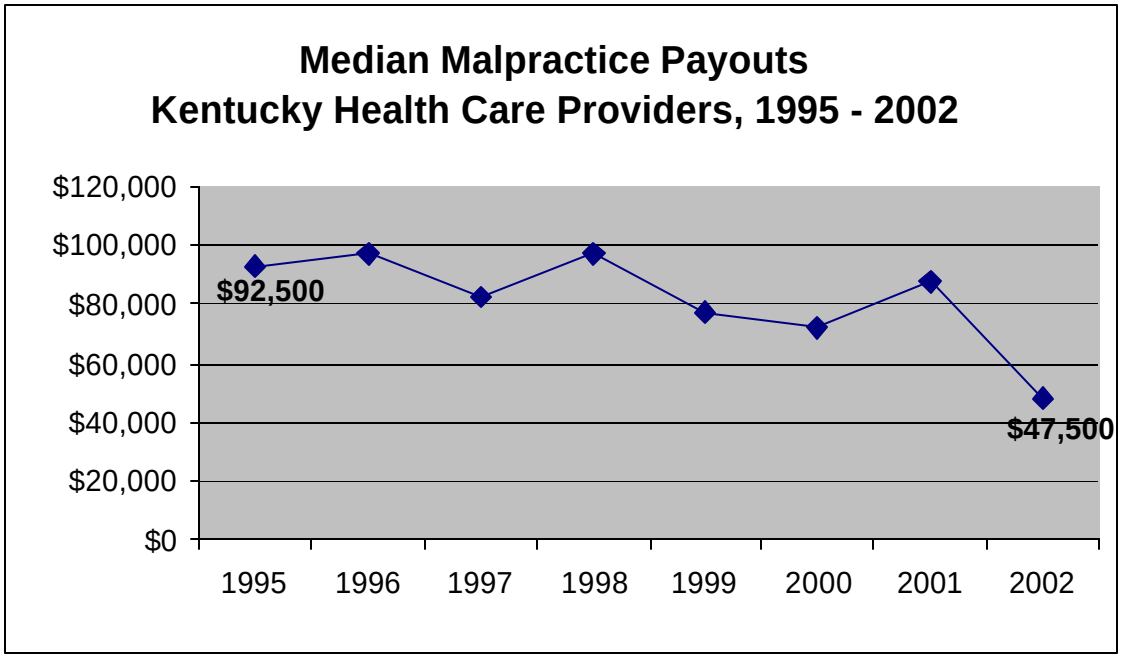
Despite a belated designation by the American Medical Association as a "crisis" state,[5] Kentucky has consistently ranked among those states with the lowest median medical malpractice payouts to victims. Its 10-year cumulative median payout of $75,000 places it 37th among all 50 states and the District of Columbia, according to the federal NPDB.[6]

A malpractice payout is intended to provide compensation for medical care and lost income over a patient's lifetime, so median payouts can be expected to increase along with medical costs, wages and productivity, and average life expectancy.

- **Kentucky's median malpractice payout in 2002 was only half what it was in 1995.** In 1995, the median malpractice payout in Kentucky was $92,500. By 2002, the Kentucky median had declined to $47,500 – a *drop* of 48.6 percent. [See Figure 3]

  The 2002 median payout for Kentucky was significantly lower than for preceding years, reflecting the unusual record of a single physician who made 76 payouts totaling $947,500. If payouts by this one physician were eliminated from the 2002 totals, Kentucky's median payout would have been $97,500 – only a 5.4 percent increase since 1995 and substantially below the national average. During these same years, the cost of medical services increased 30.5 percent.

## Figure 3



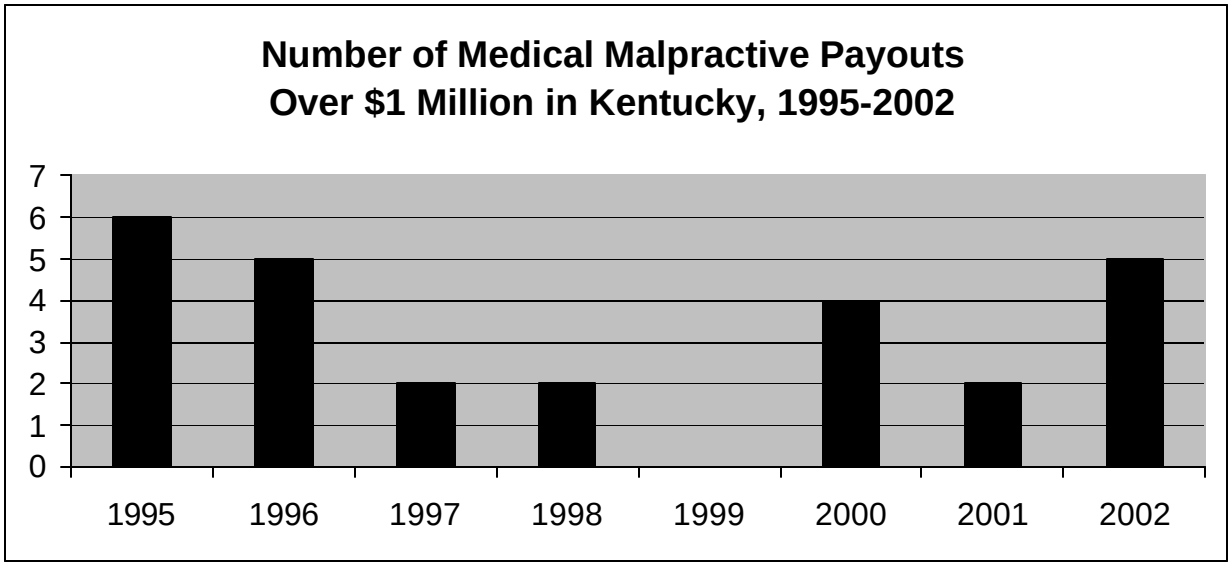

*Sources:* National Practitioner Data Bank, Jan. 1, 1995 – Dec. 31, 2002; Bureau of Labor Statistics – Medical Services CPI.

# Million-Dollar Malpractice Payouts Have Been Infrequent in Kentucky

The president of Kentucky's state Senate has stated that his proposal for placing limits on non-economic damages in malpractice cases is intended to end "a lottery atmosphere" in which "someone wants to file a lawsuit with the possibility of hitting the big lick."[7] This comment is consistent with political rhetoric used to create the impression that multi-million dollar malpractice payouts are commonplace. In fact, statistics from the federal National Practitioner Data Bank show that mega-payouts are not common in Kentucky, nor are they increasing.

- **In 2002, there was one less million-dollar medical malpractice payout than in 1995.** There were five payouts exceeding $1 million in 2002, compared with six such payouts in 1995. (The NPDB has not yet released annual totals for 2003.) The average number of payouts of $1 million or more during the past eight years has been just 3.2 annually. [See Figure 4]

## Figure 4




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

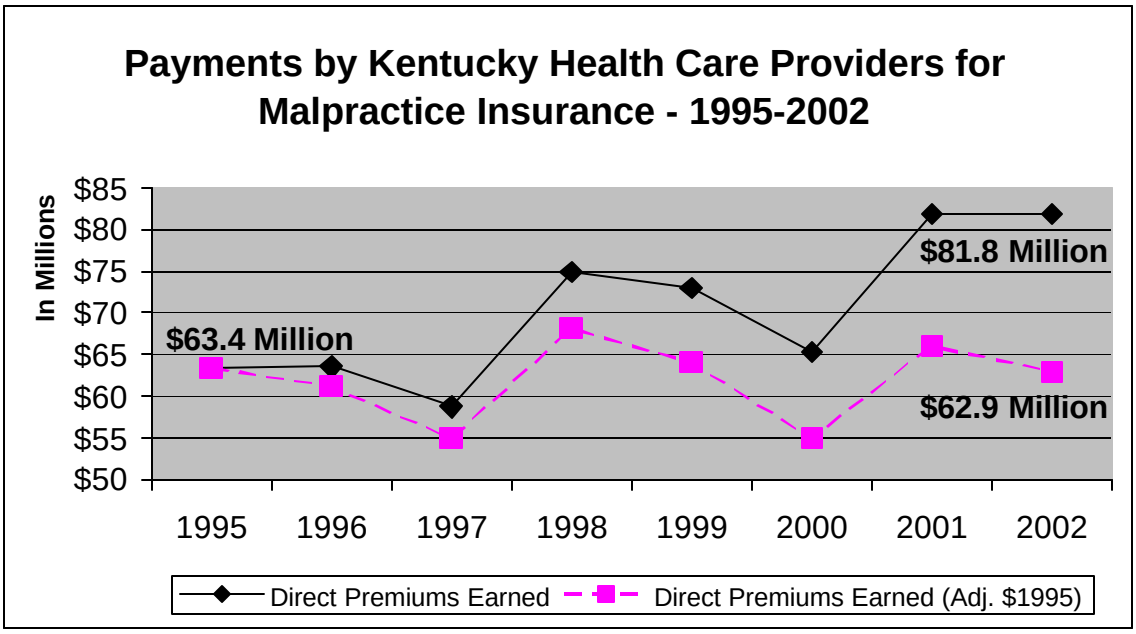
# Cost of Malpractice Insurance to Kentucky Health Care Providers Has Declined Slightly

One half or more of medical malpractice payouts to injured patients goes to cover medical bills. And the cost of medical malpractice insurance would be expected to rise significantly over the years if payouts kept pace with wages and productivity, increased life expectancy and dramatically rising health care costs. In fact, the cost of medical liability insurance in Kentucky has risen slightly slower than medical costs, as health care professionals benefited from widespread under-pricing of insurance policies.

Like much of the country, Kentucky benefited from a "soft" market for liability insurance throughout most of the 1990s, as insurance companies made profitable investments and chose not to raise malpractice insurance premiums.[8] As a result of these pricing and profit policies, the amounts that insurance companies collected in malpractice premiums, when adjusted for inflation, actually declined from 1995 to 2002 (the last year for which complete statistics are available).

- **Kentucky health care providers paid less in malpractice premiums in 2002 than in 1995, when payments are adjusted for inflation.** Measured in 1995 dollars, health care providers paid $62.9 million for malpractice coverage in 2002, compared with $63.4 million in 1995. [See Figure 5] This represents a 0.8 percent *decrease*. During these seven years, the cost of malpractice premiums increased 29 percent – from $63.4 million to $81.8 million – or 4.1 percent annually. During this same period, costs of medical services increased 30 percent – or 4.3 percent annually.

## Figure 5




*Source*: National Association of Insurance Commissioners, "Medical Malpractice Insurance Net Premium and Incurred Loss Summary," editions 1992-2001; and draft report to NAIC'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.

**Note*: Each state decides which insurance companies must report earnings/losses to the NAIC. Generally, state-administered funds, surplus lines insurers, self-insured organizations or in some cases, single-state insurers, do not report their premiums/losses. Companies reporting usually include most of the voluntary market (stock and mutual insurers) and most risk retention groups that are formed by doctors or hospitals.

# Malpractice Insurance Costs Comprise a Small Percentage of Kentucky Physician Expenses

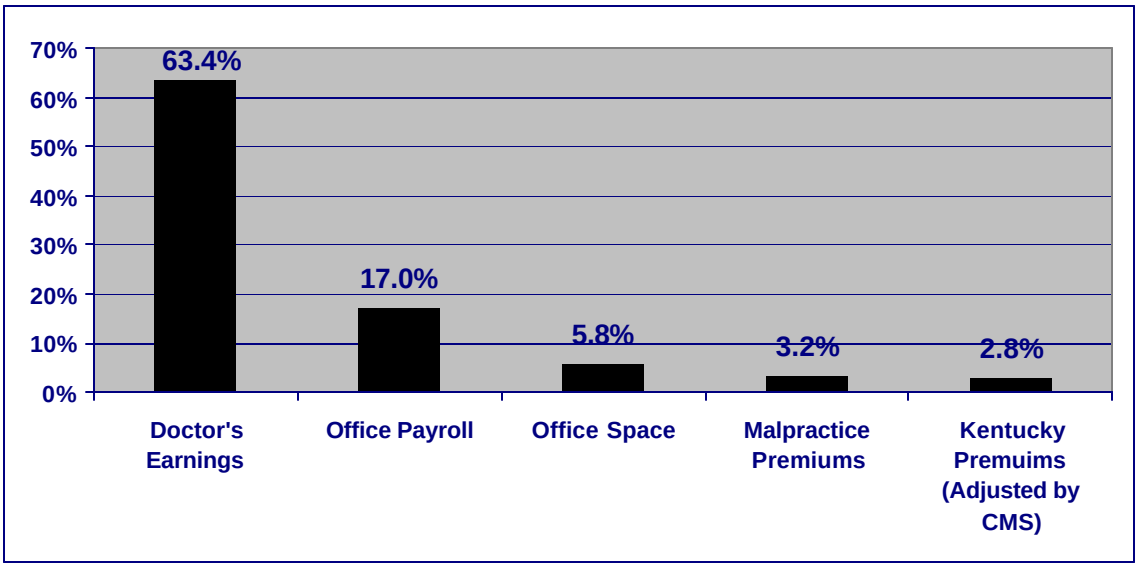
The federal government's Medicare actuary calculates that doctors spend a large amount of their practice income on their own salaries and very little for malpractice insurance.[9] The large difference between these two numbers undercuts claims that the cost of malpractice insurance is a major reason Kentucky doctors feel financial pressures.

- **Doctors allocate far more money for their salaries than they pay in malpractice premiums.** According to the federal government's Medicare program, doctors nationally spend an average of 63.4 percent of their practice incomes on their own salaries, 33.4 percent on such overhead as office payroll and rent, and only 3.2 percent of their practice incomes on malpractice insurance.[10] [See Figure 6]

- **Kentucky doctors spend less than the national average for medical malpractice insurance.** According to the federal government's Medicare program, Kentucky doctors spend an average of only 2.8 percent of their practice incomes on malpractice insurance, compared with a nationwide average of 3.2 percent.[11] This means Kentucky doctors pay 12.5 percent less than the national average.

## Figure 6

## Where Doctor's Practice Income Goes




*Sources:* "Medical Economics Magazine" Oct. 25, 1999; Office of the Actuary, Centers for Medicare and Medicaid Services (CMS).

# Claims about Doctors Abandoning Kentucky Are Contradicted by Official Data

Doctors are under intense pressure today from declining government and private sector payment rates, increased control over health care by HMOs and other managed care companies and loss of control over their personal time because of work demands. Yet, those who advocate a Kentucky constitutional amendment authorizing caps on non-economic damages in medical malpractice cases have relied on well-publicized anecdotes to bolster a perception that insurance costs are the primary reasons doctors stop practicing.[12] Government statistics, however, show that the number of doctors in Kentucky has not changed dramatically – especially not in rural counties.

- **From 2000 to 2002, Kentucky had a decline of only 19 physicians – and the loss was felt in urban areas, not rural counties.** The Kentucky Medical Association has publicly claimed that Kentucky lost 819 practicing doctors during the two years ending in 2002.[13] Official demographic statistics compiled by the Kentucky Board of Medical Licensure show that there were 8,911 licensed physicians working in Kentucky in 2000, and 8,892 physicians in 2002 – a difference of only 19 doctors. Furthermore, there was a decrease of 214 doctors in the populated counties of Jefferson and Fayette during those two years – indicating the small decline occurred in urban areas, not in rural areas where access to doctors is a more critical issue.[14]

- **Kentucky's statistics are reinforced by a General Accounting Office (GAO) report about so-called medical malpractice "crisis states."** A study released in August 2003 by the GAO essentially found that the American Medical Association and other medical-provider groups manufactured a "crisis" in health care access. The GAO study cited inaccurate reports from a number of states regarding the number of practices that had closed and the number of doctors who had departed. "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," the GAO concluded.[15] [See later section of this report, "Congressional Watchdog Agency Finds Claim of Malpractice Insurance 'Crisis' Unsubstantiated"]

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

Data compiled by the American Medical Association indicates the ratio of doctors-to-residents has grown steadily in Kentucky – 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 Kentucky residents rose from 1.62 to 2.33 – a 43.8 growth in this measurement of the prevalence of doctors.** In comparison, during the same period this measurement increased at a slower rate in four neighboring states, some of which have enacted caps on malpractice damage awards. [See Figure 7]

  Growth rates for the ratios in neighboring states include 28.2 percent in Missouri, which has a $465,000 cap (adjusted annually) on non-economic damages; 34.2 percent in Ohio, where caps have not had time to influence conditions; 40.7 percent in Tennessee, which has no caps; and 43.6 percent in Indiana, which has an overall cap of $1.25 million on all malpractice awards.

## Figure 7

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

| Year | Physicians Per 1,000 Population | | | | |
|---|---|---|---|---|---|
| | **Kentucky** (No Caps) | **Indiana** (Caps) | **Tennessee** (No Caps) | **Ohio** | **Missouri** (Caps) |
| **1985** | 1.62 | 1.56 | 1.89 | 1.99 | 1.95 |
| **1990** | 1.81 | 1.71 | 2.10 | 2.13 | 2.09 |
| **1995** | 2.11 | 2.00 | 2.47 | 2.42 | 2.36 |
| **2001** | 2.33 | 2.24 | 2.66 | 2.67 | 2.50 |
| **Percent Change 1985-2001** | + 43.8% | +43.6% | +40.7% | +34.2% | +28.2% |

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

# Five Percent of Doctors Are Responsible for Half of Kentucky Medical Malpractice Payouts

The insurance and medical communities have argued that medical malpractice litigation constitutes a giant "lottery," in which lawsuits are purely random events bearing no relationship to the care given by a physician. If the tort system is a lottery, it is clearly a rigged one, because some 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 Kentucky.

- According to the federal government's National Practitioner Data Bank, just 4.7 percent of Kentucky's doctors have been responsible for 49.9 percent of all malpractice payouts to patients. [See Figure 8] Overall, these 411 doctors, all of whom have made two or more payouts, have paid $171.9 million in damages.

- Even more surprising, just 1.6 percent of Kentucky doctors (141), each of whom has paid three or more malpractice claims, were responsible for 26.7 percent of all payouts.

- The 25 doctors with five or more payouts, just 0.3 percent of all Kentucky doctors, account for 11.4 percent of all payouts.

- 83.3 percent of Kentucky doctors have not made a medical malpractice payout since September 1990, when the NPDB was created.

## Figure 8

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

| Number of Payout Reports | Number of Doctors Who Made Payouts | Total Number of Payouts | Percent/Total Doctors (8,714)* | Percent of Total Number of Payouts | Total Amount of Payouts |
|---|---|---|---|---|---|
| All | 1,450 | 2,074 | **16.7%** | **100.0%** | $375,597,100 |
| 1 | 1,039 | 1,039 | **11.9%** | **50.1%** | $203,743,100 |
| 2 or more | 411 | 1,035 | **4.7%** | **49.9%** | $171,854,000 |
| 3 or more | 141 | 553 | **1.6%** | **26.7%** | $76,429,750 |
| 4 or more | 55 | 333 | **0.6%** | **16.1%** | $36,896,000 |
| 5 or more | 25 | 236 | **0.3%** | **11.4%** | $22,157,500 |

*Source:* National Practitioner Data Bank, Sept. 1, 1990 – Dec. 31, 2002.
* Based on number of physicians in Kentucky in 1997, the midpoint of the time period studied, as reported by the American Medical Association.

# Doctors with Repeated Malpractice Claims Against Them Suffer Few Consequences

The Kentucky Board of Medical Licensure and the state's health care providers have done little to rein in those doctors who repeatedly make medical errors and commit medical negligence. According to the National Practitioner Data Bank and Public Citizen's analysis of NPDB data, disciplinary actions (license suspension or revocation, or a limit on clinical privileges) have been few and far between for Kentucky physicians. [See Figure 9]

- Only 9.9 percent (41 of 411) of Kentucky doctors who made two or more malpractice payouts were disciplined by the Board.
- Only 12 percent (17 of 141) of Kentucky doctors who made three or more malpractice payouts were disciplined by the Board.
- Only 20 percent (11 of 55) of Kentucky doctors who made four or more malpractice payouts were disciplined by the Board.
- Only 24 percent (6 of 25) of Kentucky doctors who made five or more malpractice payouts were disciplined by the Board.

## Figure 9

### Number of Kentucky Doctors with Two or More Medical Malpractice Payouts Who Have Been Disciplined (Reportable Licensure Actions), 1990 – 2002

| 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 | 411 | 41 | 9.9% |
| 3 or more | 141 | 17 | 12.0% |
| 4 or more | 55 | 11 | 20.0% |
| 5 or more | 25 | 6 | 24.0% |
| 10 or more | 2 | 2 | 100.0% |

*Source:* National Practitioner Data Bank, Sept. 1, 1990 – Dec. 31, 2002.

# Examples of Repeat Offenders Who Have Gone Undisciplined

The extent to which Kentucky doctors make multiple payouts to patients for medical malpractice claims and are not disciplined is illustrated by the following NPDB descriptions of 13 physicians licensed in Kentucky who have made between four and eight malpractice payouts yet have not been disciplined by the state:[16]

- **Physician Number 14691** made six malpractice payments between 1992 and 2000, four times for improper performance of surgery and twice for failure to make a diagnosis. The damages add up to $4,286,250.

- **Physician Number 14734** made six malpractice payments between 1991 and 2002 for a retained foreign body in obstetrics, a retained foreign body in surgery, a failure to obtain consent or lack of informed consent in surgery, and unspecified surgery error, and two unspecified obstetrics errors. The damages add up to $3,581,250.

- **Physician Number 14293** made five malpractice payments between 1993 and 2002 for a delay in diagnosis, improper performance of a treatment or a procedure, improper management of a course of treatment, improper intubation, and an unspecified treatment error. The damages add up to $2,402,500.

- **Physician Number 14556** made four malpractice payments between 1992 and 2001 for twice failing to manage pregnancies, a delay in diagnosis and an unspecified obstetrics error. The damages add up to $2,237,500.

- **Physician Number 18027** made six malpractice payments between 1993 and 2000 for improper performance of surgery three times, two diagnosis errors and an unspecified error in surgery. The damages add up to $1,557,500.

- **Physician Number 179088** made six malpractice payments in 2001 and 2002, all for surgery-related matters. The damages add up to $1,057,500.

- **Physician Number 98985** made four malpractice payments in 1996 and 2003 for two obstetrics matters, improper performance of surgery, and a treatment error. The damages add up to $990,000.

- **Physician Number 14497** made five malpractice payments between 1992 and 2000, three times for failing to make a diagnosis, once for a delay in diagnosis and once for improper management of a course of treatment. The damages add up to $966,500.

- **Physician Number 14270** made five malpractice payments between 1991 and 2003, twice for improper management of a course of treatment, once for improper management of a

procedure, once for improper management of a surgery and once for improper performance of surgery. The damages add up to $965,000.

- **Physician Number 14299** made five malpractice payments between 1994 and 2001 for a monitoring error, ordering the wrong medication, and three obstetrics errors. The damages add up to $877,500.

- **Physician Number 14584** made four malpractice payments between 1993 and 2002, twice for failing to identify or treat fetal distress and twice for unspecific obstetrics errors. The damages add up to $855,000.

- **Physician Number 14609** made four malpractice payments between 1993 and 2001, twice for improper performance of surgery, once for improper management of surgery and once for administering the wrong dosage of the correct medication. The damages add up to $833,750.

# Congressional Watchdog Agency Finds Claim of Malpractice Insurance "Crisis" Unsubstantiated

For more than a year, the Kentucky Medical Association has made claims that Kentucky doctors are about to face a medical malpractice crisis and that the health of Kentucky residents will be at risk as doctors leave certain types of specialties – if not the state. These claims are similar to those made by doctors in other states over the last year – and they have largely been found to be unsubstantiated.

A study released in August 2003 by the General Accounting Office (GAO) essentially found that the American Medical Association and other medical-provider groups manufactured a "crisis" in health-care access to push their agenda of changing the medical malpractice system to take away patients' legal rights.[17] Ironically, the report was requested by three Republican House committee chairs who support restricting patients' legal rights in malpractice cases.

For several years, congressional lawmakers have considered a measure to cap non-economic damages provided to victims of medical malpractice at $250,000. Proponents of the measure regularly cited the AMA's information.

The GAO compared conditions in five AMA-designated "crisis states" – Florida, Mississippi, Nevada, Pennsylvania, West Virginia – to four states that the GAO determined had no reported problems – California, Colorado, Minnesota and Montana. Eighteen of the GAO report's 41 pages are devoted to debunking claims that doctors in AMA-designated "crisis states" were no longer providing care to patients. Principle findings include:

- The volume of medical care delivered to patients in the five crisis states had *increased* during the period in which the AMA suggested it was decreasing.

- Claims that the overall number of doctors in the AMA-designated "crisis states" had not declined were based on questionable surveys, echoing findings made by Public Citizen in reports on medical malpractice conditions in states released earlier this year.[18]

- The AMA's claims that medical malpractice insurance rates had made medical services unavailable in particular areas were not reliable. The investigators found that other factors, such as the rural character or economic circumstances of an area, created conditions that made it hard to attract or keep physicians.

The GAO report indicates that the AMA quarreled with these findings when shown the agency's first draft, but that GAO researchers concluded the AMA complaints were unfounded. Although the AMA could have offered the GAO access to its own Physician Masterfile, which the AMA calls the most comprehensive source of physician data in existence, the AMA did not provide the data and instead quibbled with other methodological details.

Among the GAO's other findings:

- In Florida, where Gov. Jeb Bush has shepherded a cap on damages to passage in the Legislature, "Reports of physician departures … were anecdotal, not extensive, and in some cases … inaccurate. For example, state medical society officials told us that Collier and Lee counties lost all of their neurosurgeons due to malpractice concerns; however, we found at least five neurosurgeons currently practicing in each county as of April 2003. … [O]ver the past 2 years the number of new medical licenses issued has increased and physicians per capita has remained unchanged."[19]

- "In Nevada, 34 OB/GYNs reported leaving, closing practices, or retiring due to malpractice concerns; however, confirmatory surveys conducted by the Nevada State Board of Medical Examiners found nearly one-third of these reports were inaccurate. … Random calls [GAO] made to 30 OB/GYN practices in Clark County found that 28 were accepting new patients. … Similarly, of the 11 surgeons reported to have moved or discontinued practicing, the board found four were still practicing."[20]

- "In Pennsylvania, despite reports of physician departures, the number of physicians per capita in the state has increased slightly during the past six years. The Pennsylvania Medical Society reported that between 2002 and 2003, 24 OB/GYNs left the state due to malpractice concerns; however, the state's population of women age 18 to 40 fell by 18,000 during the same time period."[21]

- Job actions by the AMA, its state affiliates, and member doctors to protest rising insurance rates limited the access of their patients to certain medical services. Specifically, the GAO found that in Nevada, "To draw attention to their concerns about rising medical malpractice premiums, over 60 orthopedic surgeons in [Clark] County withdrew their contracts with the University of Nevada Medical Center, causing the state's only Level I trauma center to close for 11 days in July 2002." And, in Florida, "at least 19 general surgeons who serve [Jacksonville's] hospitals took leaves of absence beginning in May 2003 when state legislation capping non-economic damages for malpractice cases at $250,000 was not passed."[22]

- 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."[23]

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

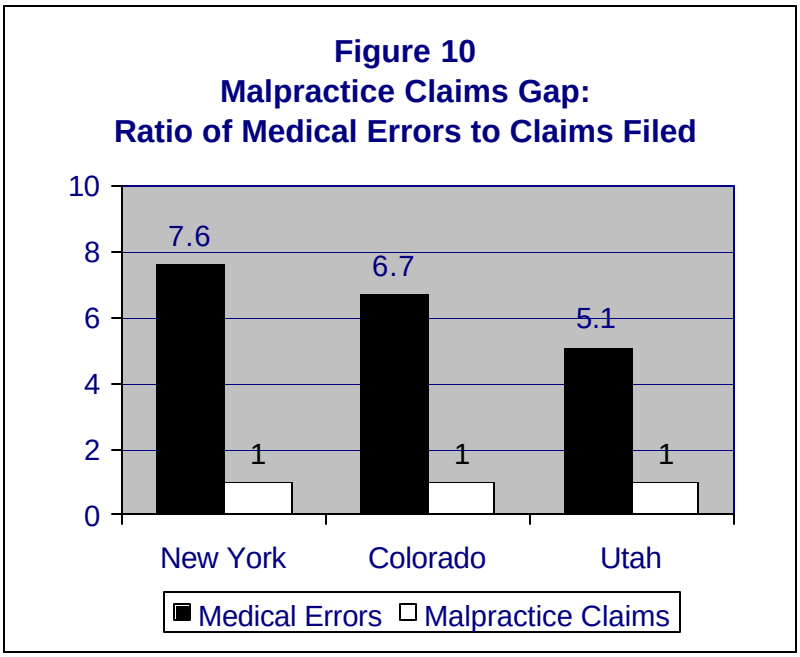
Although no comparable studies have been cited in Kentucky, there is convincing evidence from around the nation that the majority of patients who suffer injuries from medical malpractice never file lawsuits.

- **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.[24] Researchers replicating this study made similar findings in Colorado and Utah.[25] [See Figure 10]

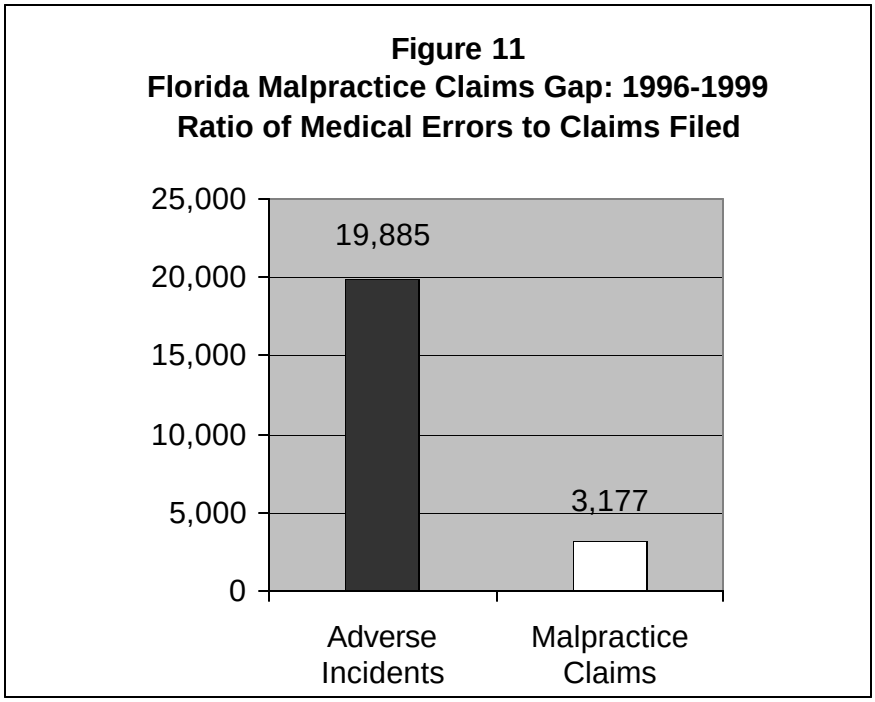
- **Actual numbers collected by government agencies show a similar claims gap.** A Florida statute requires hospitals to report "adverse incidents," defined as "an event over which health care personnel could exercise control" that results in death or injury. Tables prepared by Florida's Agency for Health 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.[26] In other words, for every six preventable medical errors only one claim is filed. [See Figure 11]

- **Malpractice insurance costs amount to only 3.2 percent of the average physician's revenues.** According to experts at the federal government's Medicare Payment Advisory Commission (MedPAC), who have no axe to grind about medical liability, liability insurance premiums make up just a tiny part of a physician's expenses and have increased by only 4.4 percent over the last year.[27] The increase in this expense is noticeable primarily because of the decreases in reimbursements that doctors are receiving from HMOs and government health programs.

- **The compensation gap helps explain why, although medical injuries are costly, expenditures on medical liability comprise less than 2 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."[28]




*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).




*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.

# Few Malpractice Lawsuits Are "Frivolous"

Lobbyists for the Kentucky Medical Association and the Kentucky Hospital Association have claimed that medical liability insurance will become affordable only if patients and their lawyers can be discouraged from filing lawsuits that "inflate malpractice costs."[29]

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.[30]

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.[31] If the case goes to trial, the costs can easily be doubled.[32] 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.[33] 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.[34] 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.

# 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.[35]

- **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."[36]

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."[37]

- **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.[38] There were nine such instances in Florida in 2001.[39] 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.[40] 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."[41]

- **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.[42] 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."[43] 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"?[44] Previously, consultants retained by medical provider groups have argued that medical providers *overspend* on precautionary measures by five to nine percent.[45]

- **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.[46] One report found specifically that each additional patient per nurse corresponded to a 7 percent increase in both patient mortality and deaths following complications.[47] Nevertheless, nursing shortages persist, even though the defensive medicine theory predicts.

# 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."

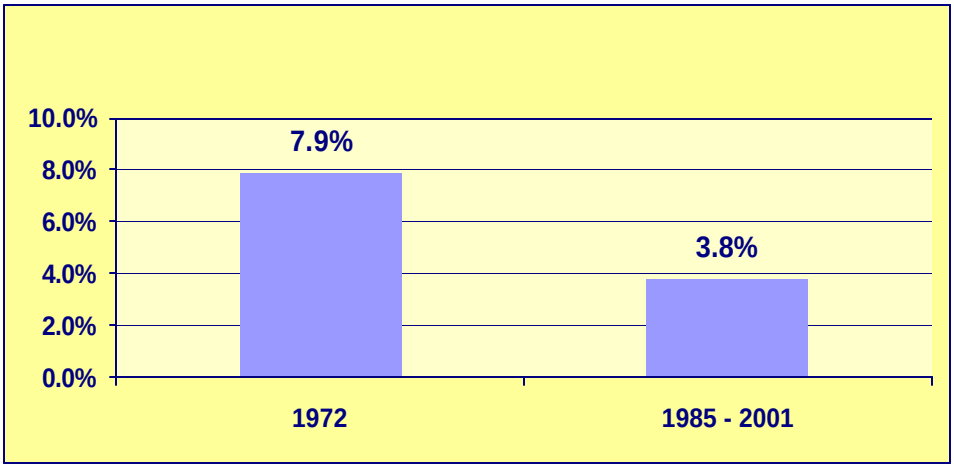
- The number and severity of claims dropped dramatically. In 1972, anesthesiologists were the target of 7.9 percent of all medical malpractice claims, double their proportion among physicians. But from 1985 to 2001, they were targets of only 3.8 percent of claims. [See Figure 12]

- In the 1970s, 64 percent of anesthesiology claims involved permanent disability or death; by the 1990s, only 41 percent did. [See Figure 13]

- 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 14]

## Figure 12

## Percent of Malpractice Claims Involving Anesthesiologists



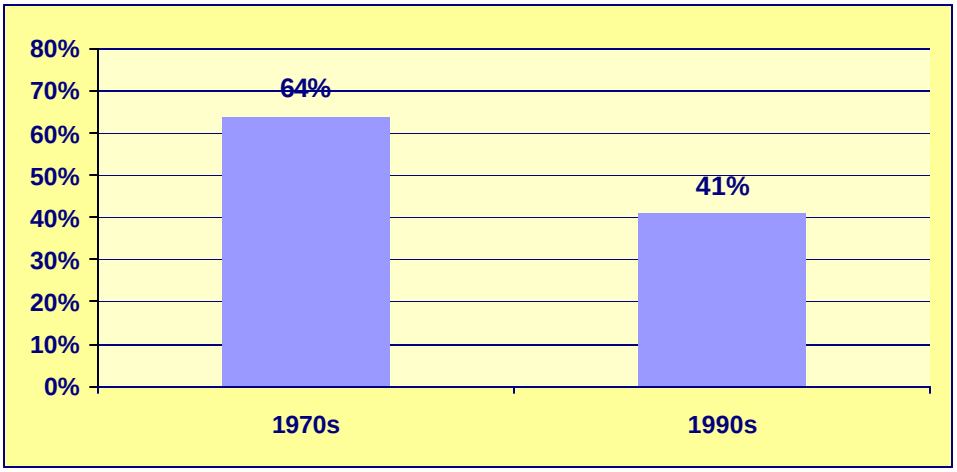

*Sources:* U.S. Department of Health, Education and Welfare, Secretary's Commission on Medical Malpractice, 1973; Physician Insurers Association of America, Cumulative Data Sharing Report, January 1, 1985 – December 31, 2001.

- 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 15]

- 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 16]

## Figure 13

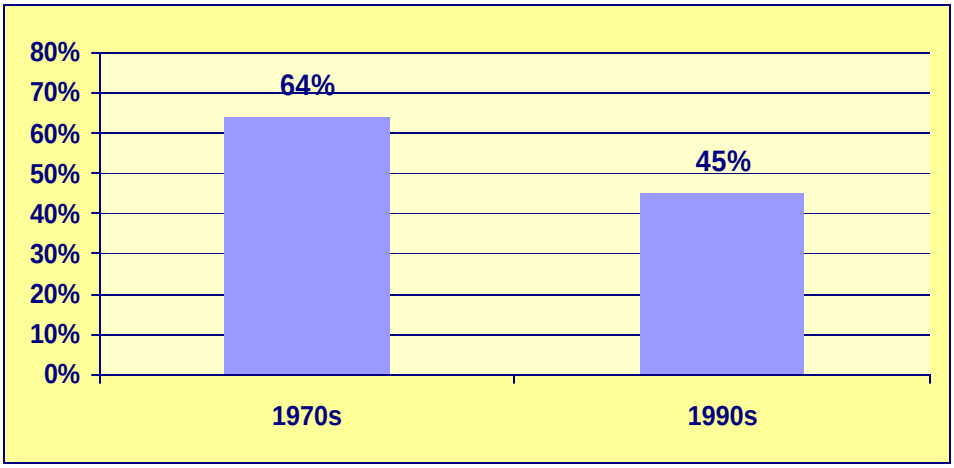
## Anesthesia Claims Involving Permanent Disability or Death, 1970s and 1990s




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

## Figure 14

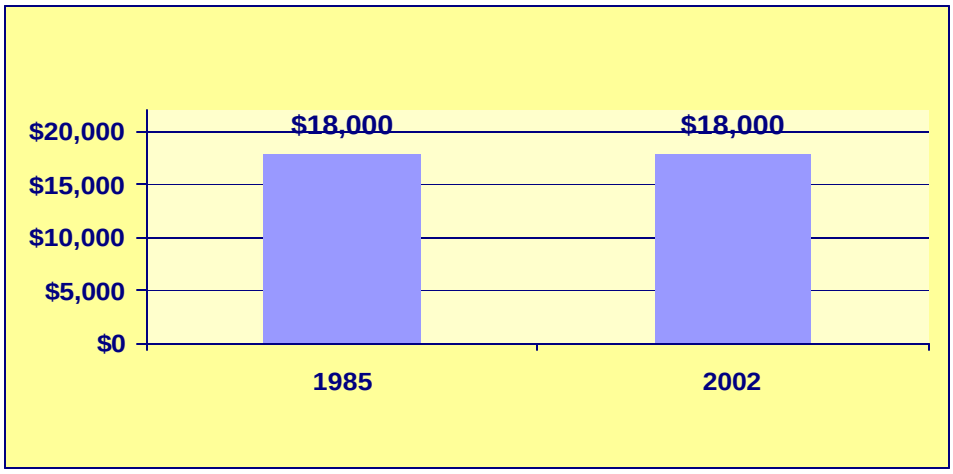
## Percent of Anesthesia Claims Closed with Payment, 1970s and 1990s




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

## Figure 15

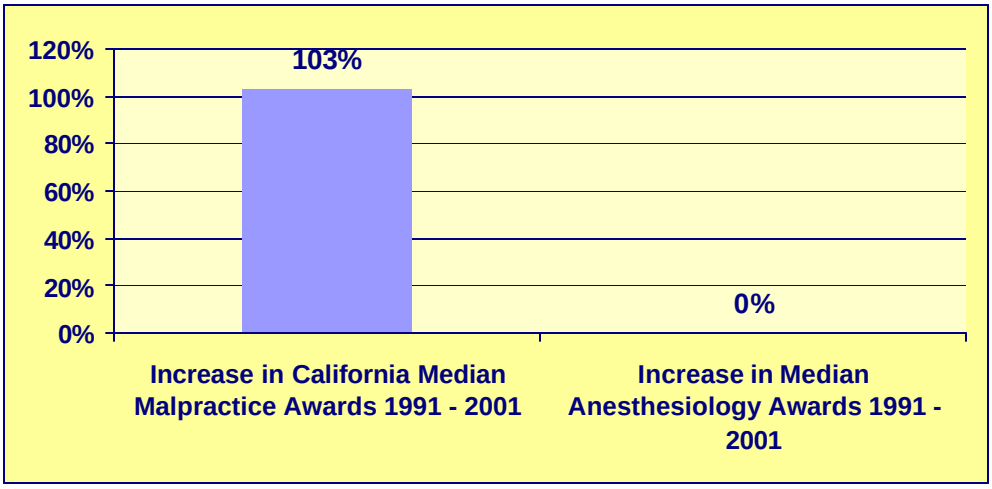
## Average Premium for Anesthesiologists 1985 and 2002




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

## Figure 16

## 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.

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

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

- **Congressional Budget Office links rising premiums to insurance company investment losses.** In January 2004, the Congressional Budget Office noted that the 15 biggest medical malpractice insurers saw their investment returns drop by 1.6 percent from 2000 through 2002. "That figure corresponds to almost half of the 15 percent increase in [medical malpractice premium] rates estimated by the Centers for Medicare and Medicaid Services," the CBO reported.[48]

- **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."[49]

- **Medical liability premiums track investment results.** J. Robert Hunter, one of the country's most knowledgeable insurance actuaries and director of insurance for the Consumer Federation of America, recently analyzed the growth in medical liability premiums.[50] He found that premiums charged do not track losses paid, but instead rise and fall in concert with the state of the economy. When the economy is booming and investment returns are high, companies maintain premiums at modest levels; however, when the economy falters and interest rates fall, companies increase premiums in response.

- **The same trends are present in other lines of insurance.** Property/casualty refers to a large group of liability lines of insurance (30 in total) including medical malpractice, homeowners, commercial, and automobile. The property/casualty insurance industry has exhibited cyclical behavior for many years, as far back as the 1920s. These cycles are characterized by periods of rising rates leading to increased profitability. Following a period of solid but not spectacular rates of return, the industry enters a down phase where prices soften, supply of the insurance product becomes plentiful, and, eventually, profitability diminishes, or vanishes completely. In the down phase of the cycle, as results deteriorate, the basic ability of insurance companies to underwrite new business or, for some companies even

to renew some existing policies, can be impaired. This is because the capital needed to support the underwriting of risk has been depleted through losses.

The current market began to harden in 2001, following an unusually prolonged period of soft market conditions in the property-casualty section in the 1990s. The current hard market is unusual in that many lines of insurance are affected at the same time, including medical malpractice. As a result, premiums are rising for most types of insurance. The increases have taken policyholders by surprise given that they came after several years of relatively flat to decreasing prices.[51]

- **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."[52] 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."[53]

- **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."[54]

- **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." [55]

- **Financial analysts recognize 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."[56] 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."[57]

  "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."[58]

# Caps on Damages Are a False "Solution"

The Kentucky legislature is considering a constitutional amendment that would authorize limiting non-economic damages, also known as "pain-and-suffering," to $250,000 in medical malpractice cases. Such a cap would affect few cases and, thus, have little impact on insurance rates. More important, limits on awards for pain and suffering penalize severely injured patients the most and reduce accountability, thereby lessening deterrence against errors and negligence.

- **A cap of $250,000 on non-economic awards would have affected about 8.4 percent or fewer of the malpractice payouts made in Kentucky during 2002.** Proponents of caps on non-economic awards in malpractice cases insist that such limits will drastically reduce the number of large payouts to patients. Kentucky's 2002 statistics suggest otherwise.

  In medical malpractice payouts, it is unusual for non-economic damages to comprise more than one-third to one-half of the total payout. Of 261 payouts reported to the NPDB from Kentucky for 2002, only 22 – or 8.4 percent – were more than $500,000 in combined economic and non-economic damages (likely to be affected by a $250,000 non-economic cap). And only 15 payouts – 5.7 percent – were for more than $700,000 in combined economic and non-economic damages (likely to be affected by a $350,000 non-economic cap). Such a small universe of cases make it unlikely even a draconian cap of $250,000 would affect insurance rates. [See Figure 17]

## Figure 17

### Kentucky Medical Malpractice Payouts That Would Have Been Affected by a $250,000 or $350,000 Cap – 2002

| Payouts Over $500,000 | Payouts Over $700,000 |
|---|---|
| 22 | 15 |

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

- **"Non-economic" damages are not as easy to quantify as lost wages or medical bills, but they compensate real injuries.** So-called "non-economic" damages are awarded for the pain and suffering that accompany any loss of normal functions (e.g. blindness, paralysis, sexual dysfunction, lost bowel and bladder control, 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. 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.

- **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.[59] In total, the studies examined more than 3,500 medical malpractice jury verdicts and found a consistent relationship between the severity of the injury and the size of the verdict. Uniformly the authors concluded that their findings did not support the criticism that jury verdicts are frequently unpredictable and irrational.

- **The insurance industry's own statistics demonstrate that awards are proportionate to injuries.** The PIAA Data Sharing Report also demonstrates the relationship between the severity of an injury and the size of the settlement or verdict.[60] PIAA, as do most researchers, measures severity of injury according to the National Association of Insurance Commissioners' classifications.[61] The average indemnity paid per file was $49,947 for the least severe category of injury and increased with severity, to $454,454 for grave injuries. All researchers found that the amount of jury verdicts fell off in cases of death, for which the average indemnity was $195,723. This is not surprising, as the costs of medical treatment for a grave injury are likely to be greater, and pain and suffering would be experienced over a longer time period than in the case of death.[62]

- **Capping awards hurts children, women 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. 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.

# Insurance Companies and Their Lobbyists Admit 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.

### Premium on the Truth:

"Insurers never promised that tort reform would achieve specific savings." – American Insurance Association[63]

"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[64]

"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[65]

### 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.[66]

### 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.[67]

### Illinois

"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." – Leo Jordan, retired vice president and counsel for Illinois-based State Farm Insurance Companies and past chair of the American Bar Association's Tort Trial and Insurance Practice Section.[68]

### 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[69]

### 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.[70]

"[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[71]

### 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."[72]

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."[73]

### 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.[74]

"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[75]

### 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[76]

# Health-Care Providers and Legislators Should Focus on Patient Safety Reforms

Physician groups, insurance companies and their political allies have essentially blamed patients and their lawyers for the temporary spike in some insurance premiums. The Kentucky Medical Association and its political supporters have continued to decry the costs of patient litigation, despite the fact that the state has a $620,000 cap "non-economic" damages, which are awarded for the pain and suffering and loss of lifestyle due to paralysis, severe brain damage, disfigurement, blindness and deafness, of the loss of childbearing ability. Such damages exceed $620,000 only in extreme cases of permanent significant injuries.

Efforts to convince politicians and policymakers that rising insurance rates are a result of "frivolous" lawsuits simply shifts attention away from much more serious problems. Instead, Kentucky's regulators, officeholders and health-care providers should focus on improving patient safety. Public Citizen recommends the following patient safety reforms:

## Federal Patient Safety Reforms

- **Open the National Practitioner Data Bank to Empower Consumers with Information About Their Doctors.**
  Information about doctor discipline, including state sanctions, hospital disciplinary actions and medical malpractice awards is also contained in the National Practitioner Data Bank. HMOs, hospitals and medical boards can look at the National Practitioner Data Bank. Unfortunately, consumers cannot access the information because the names of physicians in the database are kept secret from the public. Congress should lift the veil of secrecy and allow the people who have the most to lose from questionable doctors to get the information they need to protect themselves and their families.

## State Patient Safety Reforms

- **Improve Oversight of Physicians.**
  Public Citizen has long sought greater consumer access to information about doctors, and there have been recent improvements in making that information available. Most state medical boards now provide some physician information on the Internet, but the information about disciplinary actions varies greatly, is often inadequate and can be difficult for people to access.[77]

  For more than a decade, Public Citizen's Health Research Group has been carefully scrutinizing the performance of state medical boards. As reported in our *Questionable Doctors* publication,[78] too little discipline is being done. Too many state medical boards, despite their duty to protect the public, still believe their first responsibility is to rehabilitate "impaired physicians" and shield them from the public's prying eyes. Fewer than one-half of

one percent of the nation's doctors face any serious state sanctions each year. In 2002, state medical boards took 2,868 serious disciplinary actions, a pittance given estimates that between 44,000 and 98,000 deaths of hospitalized patients are caused by preventable medical errors annually.

State discipline rates ranged from 11.87 serious actions per 1,000 doctors (Wyoming) to 1.07 actions per 1,000 physicians (Hawaii), a tenfold difference between the best and worst states. Although Kentucky is ranked 4th among the 50 states and the District of Columbia with 7.58 serious actions taken per 1,000 physicians, its rate is still well below the 11.87 rate of top-ranked Wyoming. (Note: Most of these actions are unrelated to medical malpractice and instead involve sanctions for substance abuse, sexual and criminal offenses.)

If all the boards did as good a job as the lowest of the top five boards, Oklahoma's rate of 7.56 serious disciplinary actions per 1,000 physicians, it would amount to a total of 6,089 serious actions a year. That would be 3,225 more serious actions than the 2,864 that actually occurred in 2002. It is likely that patients are being injured or killed more often in states with poor doctor disciplinary records than in states with consistent top performances.

Negligent doctors are rarely disciplined with loss or suspension of their license for inferior care. Instead, state medical boards focus on more easily documentable offenses such as prescription drug violations and fraud convictions or disciplinary action in another state as potential indicators of substandard care. Congress could encourage better oversight through grants to state medical boards, tied to the boards' agreements to meet performance standards.

The following state reforms would improve medical board performance:

- **Reform medical board governance.** States should sever any remaining formal, debilitating links between state licensing boards and state medical societies. Members of medical boards (and separate disciplinary boards, where present) should be appointed by the governor, and the governor's choice of appointees should not be limited to a medical society's nominees. At least 50 percent of the members of each state medical board and disciplinary board should be well-informed and well-trained public members who have no ties to health care providers and who, preferably, have a history of advocacy on behalf of patients. The governor should appoint members to the Medical Board whose top priority is protecting the public's health, not providing assistance to physicians who are trying to evade disciplinary actions.

- **Beef up medical board funding and staffing.** State legislatures should permit medical boards to spend all the revenue from medical licensing fees, rather than being forced to give part to the state treasury. The medical boards should raise their fees to $500 a year. All boards could benefit from hiring new investigators and legal staff. Boards should employ adequate staff to process and investigate all complaints within 30 days, to review all malpractice claims filed with the board, to monitor and regularly visit doctors who have been disciplined to ensure their compliance with the sanctions imposed, and to ensure compliance with reporting requirements. They should hire investigators to seek out errant doctors,

through review of pharmacy records, consultation with medical examiners, and targeted office audits of those doctors practicing alone and suspected of poor care.

- **Require risk prevention.** States should adopt a law, similar to one in Massachusetts, that requires all hospitals and other health care providers to have a meaningful, functioning risk prevention program designed to prevent injury to patients. Massachusetts also requires all adverse incidents occurring in hospitals or in doctors' offices to be reported to the medical board.

- **Require periodic recertification of doctors based on a written exam and audit of their patients' medical care records.**

## Federal and State Patient Safety Reforms

- **Implement patient safety measures proposed by the Institute of Medicine.** Public Citizen believes in personal responsibility and accountability for negligence as one of the principal methods for deterring medical errors. Nevertheless, we acknowledge that the "systems approach" to patient safety advocated by the Institute of Medicine shows considerable promise. We are disappointed that some three years after the release of its report, almost nothing has been done to establish mandatory nationwide error reporting systems, identify unsafe practices, or raise performance standards.

  Medication errors are among the most common preventable mistakes, but safety systems have been put in place in very few hospitals. Although experts using the systems approach have identified a number of promising strategies to reduce malpractice, few have been implemented. Experts have estimated that more than 950,000 serious drug errors occur annually in hospitals alone.[79] Recent studies show that computer physician order entry (CPOE) systems can reduce error rates by 55 percent,[80] CPOE is an electronic prescribing system that intercepts errors where they most commonly occur – at the time medications are ordered. Physicians enter orders into a computer, rather than on paper. Orders are automatically checked for potential problems, such as drug interactions or allergies. CPOE also resolves problems associated with deciphering doctors' notoriously bad handwriting. But in spite of these benefits, fewer than three percent of hospitals have fully implemented CPOE.[81]

- **Evidence-based hospital referral could save 4,000 lives every year, but has not been implemented.** Evidence-based hospital referral means directing patients with high-risk conditions to hospitals with characteristics shown to be associated with better outcomes. Dr. Adams Dudley, a researcher at the University of San Francisco at California, identified 10 surgical procedures for which outcomes were strongly related to hospital volume. Using data from California hospitals, he estimated that using evidence-based hospital referral for those 10 procedures would prevent over 4,000 deaths across the U.S. each year.[82]

- **Prevent wrong procedure surgery and surgery performed on the wrong body part or to the wrong patient.** Such mistakes should *never* happen, according to a special alert reissued December 5, 2001 by the Joint Commission on Accreditation of Healthcare Organizations.[83] To prevent these accidents, the JCAHO recommends the surgical site be marked with a permanent marker. Sometimes referred to as "signing your site," doctors place their initials on the surgical site with a permanent marking pen in a way that cannot be overlooked and then actually operate through or next to the initials. JCAHO also recommends orally verifying the surgery in the operating room just before starting the operation.[84] Nevertheless, during 2001 in Florida hospitals alone there were 54 surgeries on the wrong part of the body, 16 wrong procedures performed and nine wrong patient surgeries.[85] Had Florida mandated the JCAHO recommendations in 2000, these 79 incidents would not have occurred.

- **Limit physicians' workweek to reduce hazards created by fatigue.** American medical residents work among the highest – if not the highest – number of hours in the professional world. They work up to 120 hours a week, including 36-hour shifts for several weeks at a time.[86] After 24 hours of wakefulness, cognitive function deteriorates to a level equivalent to having a 0.10 percent blood alcohol level.[87] In other words, doctors who would be considered too unsafe to drive may still treat patients for 12 more hours. 41 percent of resident-physicians attribute their most serious mistake in the previous year to fatigue.[88] 45 percent of residents who sleep less than four hours per night report committing medical errors.[89] Working these extreme hours for years at a time also has ill-effects on doctors' own personal health and safety. Multiple studies in the medical literature demonstrate that sleep-deprived and overworked residents are at increased risk of being involved in motor vehicle collisions, suffering from depressed mood and depression, and giving birth to growth-retarded and/or premature infants.[90] If the maximum workweek for residents was limited to 80 hours it could considerably reduce mistakes due to fatigue and lack of supervision.

# Solutions to Make Insurance Rates More Predictable

The following recommendations for state insurance regulators to implement have been made by J. Robert Hunter, Director of Insurance for the Consumer Federation of American, on behalf of Americans for Insurance Reform:[91]

## Investigations and Audits

There must be a full and thorough investigation of the insurance companies' data to determine if there are errors and over-reserving in the data. An investigation should determine:

1) The extent to which the extraordinarily high profitability of the insurance industry during much of the 1990s, and its lower profitability today, is related to the performance of interest rates and the stock market during those periods;

2) The extent to which today's rate increases are an attempt to recoup money that insurers lost in the stock market or in other poorly-performing assets;

3) The extent to which insurers are adversely affected by today's low interest rates;

4) Whether insurers' estimates of their future claims payments, which are the basis for rate increases, are unreasonably high today; and

5) Whether it is proper, or lawful, for insurers to seek substantial rate increases despite having hugely increased their surplus – the money they have "in the bank," with policyholder-supplied funds, particularly if the insurer is overcapitalized.

In addition, state insurance commissioners are urged to institute, or seek statutory authority to institute, annual, rather than the typical once-every-three-years, audits of insurance companies operating in their state. These annual audits should ascertain whether the companies are engaging in questionable accounting practices and whether their business and investment practices, by failing to take into account cyclical economic downturns, present unacceptable financial risks for insurance consumers and shareholders.

## Specific Reforms

- **Regulate excessive pricing.** One cause of the cycle is the lack of regulatory action to end excessive and inadequate rates during the different phases of the cycle. Insurance Commissioners should start now by regulating the excessive prices being charged by insurers. They should, at least, hold the necessary hearings to determine if the prices are not excessive.

- **Freeze particularly stressed rates until the examination of the prices and remarkable jumps in loss reserves can be fully analyzed.** For instance, medical malpractice and homeowner rates should be frozen. A rollback of unjustified rate increases that have already taken effect should then be in order. (The manner in which insurance rate rollbacks can be written and implemented to comply with all Constitutional requirements is explained in *Calfarm Ins. Co. v. Deukmejian*, 48 Cal.3d 805 (1989), and *20th Century Ins. Co. v. Garamendi*, 8 Cal.4th 216 (1994). These cases substantially upheld Prop 103, the California insurance reform initiative that rolled back auto insurance rates by 20 percent.)

- **Require that risks with poorer experience pay more than good risks in lines of insurance where such methods are not in use today.** For example, require medical malpractice insurers to use claims history as a rating factor, and to give that factor significant weight. Auto insurers use an individual's driving record as a rating factor; workers compensation insurers use the employer's loss experience as a rating factor – so-called "experience mod." Malpractice insurers should do the same. In addition, insurance commissioners should require all medical malpractice insurers to offer all "good" doctors – *i.e.*, all doctors meeting an objective definition of eligibility based on their claims history, their amount of experience and perhaps other factors – the lowest rate.

- **Reduce the percentage of assets that insurers can invest in stocks or other risky assets.** Insurers should not be permitted to raise their rates in order to recoup losses on stocks or other risky assets. The less risky their investments, the more secure policyholders are, and the more stable are rates.

- **Create a standby public insurer to write risks when the periodic cycle bottoms and hard markets occur, such as a medical malpractice insurer funded by a start-up loan from the state to compete with the existing malpractice carriers.** Several states have created such carriers to write workers' compensation, and in many states such carriers have helped bring down workers' comp rates. Similarly structured medical malpractice insurers should have similar success.

- **Ask the National Association of Insurance Commissioners to stop implementation of the deregulation of commercial rates and forms, which it is unwisely pushing.**

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Emotional damage only (fright; no physical injury);
Temporary insignificant (lacerations, contusions, minor scars);
Temporary minor (infections, fall in hospital, recovery delayed);
Temporary major (burns, surgical material left, drug side-effects);
Permanent minor (loss of fingers, loss or damage to organs);

Permanent significant (deafness, loss of limb, loss of eye, kidney or lung);
Permanent major (paraplegia, blindness, loss of two limbs, brain damage);
Permanent grave (quadriplegia, severe brain damage, lifelong care or fatal prognosis);
Death

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