The Facts About Medical Malpractice in Maryland

Congress Watch
September 2003

Acknowledgments

The authors of *The Facts About Medical Malpractice in Maryland* are Public Citizen's Congress Watch Director Frank Clemente and Research Director Neal Pattison. Additional contributions were made by consultant Stephen Saloom, Senior Researcher Taylor Lincoln and Legislative Assistant April Greener.

About Public Citizen

Public Citizen is a 125,000 member non-profit organization based in Washington, D.C., with more than 3,600 members in Maryland. We represent consumer interests through lobbying, litigation, research and public education. Founded by Ralph Nader in 1971, Public Citizen fights for consumer rights in the marketplace, safe and affordable health care, campaign finance reform, fair trade, clean and safe energy sources, and corporate and government accountability. Public Citizen has five divisions and is active in every public forum: Congress, the courts, governmental agencies and the media. Congress Watch is one of the five divisions.

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

The Facts About Medical Malpractice in Maryland

Table of Contents

Executive Summary

Medical Mutual of Maryland, which sells malpractice insurance to 80 percent of physicians in private practice in Maryland, received a 28 percent rate increase in August 2003. Its rate request was accompanied by statements from company executives and representatives of the Maryland State Medical Society, known as MedChi, echoing the anti-patient, anti-consumer rhetoric heard earlier this year during the national medical malpractice debate – that frivolous lawsuits and skyrocketing jury awards are to blame for the cost of medical malpractice insurance.

The extent of Medical Mutual's rate hike was challenged by J. Robert Hunter, one of the country's most knowledgeable insurance actuaries and director of insurance for the Consumer Federation of America.

Moreover, during the past year Public Citizen has observed a pattern in other states whereby the American Medical Association (AMA) and its state affiliates join with insurance companies to use a temporary spike in insurance rates – caused by unfavorable economic conditions, not litigation – to demand restrictions on patients' legal rights.

In fact, an August 2003 study by the General Accounting Office (GAO) confirmed that the American Medical Association and its affiliates have spread misinformation and unsubstantiated claims to create a sense of "crisis" in states where access to medical care has *not* been jeopardized by medical malpractice insurance rates.

There are three major findings that form the core of this report:

1) There is no overall medical malpractice lawsuit problem in Maryland – the number of claims filed and payouts to injured patients are both down significantly and there is no evidence of a doctor exodus.

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

3) Just before its recent rate increase, Medical Mutual of Maryland was very profitable and in "excellent" financial health, raising questions about whether its request for a 28 percent rate increase was justified, or a political ploy to further its legislative goals of reducing patients' legal rights.

The findings in this Public Citizen report are based on the following evidence:

Section I: Lawsuits Are Not Responsible for Rising Medical Malpractice Insurance Premiums in Maryland

- **Patients and consumers suffer the real costs of medical malpractice.** Extrapolating from Institute of Medicine findings, we estimate that there are 836 to 1,862

hospital deaths in Maryland each year that are due to *preventable* medical errors. The costs resulting from *preventable* medical errors to Maryland's residents, families and communities is estimated at $323 million to $551 million each year. But the cost of medical malpractice insurance to Maryland's health-care providers is only $155.1 million a year.

- **Medical malpractice insurers benefit from declining claims in Maryland.** The number of medical malpractice legal claims filed was 11.8 percent lower in 2002 than it was in 1996. According to the Maryland Office of Health Claims Arbitration, there were 722 claims filed in Maryland in 1996, compared with 637 in 2002 – a decline of 85 claims, or 11.8 percent. Medical Mutual's reported claims declined by 11.5 percent from 1996 to 2001 – dropping from 506 to 448 respectively.

- **The number of medical malpractice legal claims filed per physician has dropped 17.6 percent since 1996.** In 1996, there were 3.4 legal claims for medical malpractice per 100 Maryland physicians, compared with 2.8 claims per 100 physicians in 2002.

- **The number of medical malpractice payouts in Maryland has remained flat since 1996.** According to the federal National Practitioner Data Bank (NPDB), in 1996 there were 230 medical malpractice payouts and in 2002 there were 266 payouts – an increase of 15.6 percent, or 2.6 percent a year. But, when adjusted for the growing number of doctors in the state, there were 1.2 malpractice payouts per 100 Maryland physicians in 2002 – barely greater than the 1996 ratio of 1.1.

- **The total amount of medical malpractice payouts in Maryland dropped almost 18 percent from 1996 to 2002, after adjusting for medical inflation.** According to NPDB data, malpractice payouts in 1996 totaled $71.3 million, compared with payouts of $73.6 million in 2002 – an increase of $2.3 million or only 3.2 percent over six years. But when adjusted for medical services inflation, malpractice payouts in Maryland actually declined 17.9 percent – from $71.3 million in 1996 to $58.5 million in 2002. In equivalent dollars, liability insurers paid out $12.8 million *less* in 2002 than they paid out in 1996.

- **The mean medical malpractice payout dropped 29 percent from 1996 to 2002, after adjusting for medical inflation.** NPDB data on payouts made to injured patients shows that the mean payout in 1996 was $310,100, compared with an average of $276,842 in 2002 – a drop of $33,258 or 10.7 percent. But when adjusted for medical services inflation, the mean malpractice payout in Maryland dropped from $310,100 in 1996 to $220,083 in 2002 – a decline of 29 percent. In equivalent dollars, liability insurers made mean payouts that were $90,017 *less* in 2002 than in 1996.

- **There were only three medical malpractice payouts of $1 million in each of the past two years.** Contrary to claims from MedChi, NPDB data reveal that there has been no explosion of million-dollar malpractice payouts in Maryland. There were three such payouts reported in 2001 and in 2002 – substantially fewer than the eight million-dollar payouts reported in 1996 and 2000. Moreover, the three million-dollar payouts in 2002 represent only 1 percent of the total number of payouts made that year.

- **Medicare's adjustment for the cost of malpractice insurance is lower for Maryland doctors than for doctors nationally.** A further indication that Maryland doctors are not unduly burdened by malpractice claims or malpractice costs can be found in the calculations by the federal Medicare actuary. According to the Medicare formula, Maryland doctors spend an average of only 2.4 to 2.9 percent of their practice incomes on malpractice insurance costs, compared with a national average of 3.2 percent.

- **There is no evidence of a doctor exodus.** MedChi officials claim that Maryland needs to impose stricter limits on malpractice compensation to patients or risk having many doctors quit their practices or leave the state. State government statistics reveal, however, that far from an "exodus" of doctors the number of resident doctors in Maryland has jumped by 1,565 since 1996, from 20,994 in 1996 to 22,559 in 2002. This is an overall increase of 7.5 percent, or 1.2 percent a year. Maryland had 38.2 doctors per 10,000 population in 2001, compared with a national average of 26.8 doctors per 10,000 population. Maryland has the fourth highest ratio of doctors-to-population among all 50 states and Washington, D.C.

- **Three percent of doctors are responsible for half the medical malpractice payouts in Maryland.** A small percentage of doctors have attracted multiple claims, and it is these doctors who are responsible for much of the malpractice in Maryland. According to NPDB data, which covers malpractice judgments and settlements since September 1990, just 3 percent of Maryland's doctors have been responsible for 50.8 percent of malpractice payouts to patients. Overall, these 576 doctors, all of whom have made two or more payouts, have paid $317.3 million in damages. Conversely, 89.4 percent of Maryland's doctors have never made a malpractice payout.

- **Doctors with repeated malpractice claims against them suffer few consequences.** The Maryland Board of Physician Quality Assurance and the state's health care providers have been criticized in the media and by lawmakers for failing to rein in doctors who repeatedly commit medical errors and medical negligence. According to Public Citizen's analysis of NPDB data, only 20.6 percent (37 of 180) of Maryland doctors who made three or more malpractice payouts since 1990 were disciplined by the Board. Disciplinary action is a license suspension or revocation, or a limit on clinical privileges.

- **The Maryland Board of Physician Quality Assurance has been among the nation's least diligent when it comes to disciplining doctors.** In 2002, Maryland ranked 46th among all states and the District of Columbia for the frequency at which it takes serious disciplinary actions against doctors for incompetence, misprescribing drugs, sexual misconduct, criminal convictions, ethical lapses or other offenses. In 2002, the Board levied serious sanctions against only 39 of its 21,833 doctors. Nationally in 2002, there were 3.6 serious actions taken for every 1,000 physicians. The rate was exactly half that in Maryland – only 1.8 serious actions per 1,000 physicians. Over the past decade, Maryland has descended sharply in its rate of doctor discipline, from its best ranking of 19th in 1993 to its worst ranking of 46th in 2002. In seven of the last 10 years, Maryland has been rated in the bottom half of all states.

- **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 were untrue; 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; and the overall number of doctors in the "crisis" states had not declined.

Section II: Medical Mutual's 28 Percent Rate Increase Is Not Justified

- **The 28 percent rate increase approved for Medical Mutual is excessive.** J. Robert Hunter, current Director of Insurance for the Consumer Federation of America, and former Texas insurance commissioner and Federal Insurance Administrator, closely examined Medical Mutual's 28 percent rate increase request. He has concluded that "there should be only a very minor increase, of the order of 2.5% to 5.0%." Among other things, Hunter finds that Medical Mutual's rate increase is faulty because the company proposes to "vastly over-reserve" to cover future payouts, overstates how much large payouts are increasing, and "vastly understates investment income potential of the [company's] reserves."

- **Medical Mutual's rate request was not justified in light of the company's recent strong profitability.** Over the last five years Medical Mutual's insurance business has gotten more profitable each year, and was more profitable in 2002 than in each of the previous four years (when it also was very profitable).

- **Medical Mutual provided a 21 percent rate discount to policyholders in 2003.** As evidence of its strong profit position and overall strong financial health, Medical Mutual provided a 21 percent "Tort Reform Dividend Credit" for all policyholders renewing in 2003. Over the last five years, Medical Mutual's returned dividends to policyholders averaged 27.2 percent a year or more than 27 cents on each dollar paid in premiums. The 28 percent rate increase certainly could be avoided if Medical Mutual decided to forgo policyholders' dividend rebates, which closely approximate the rate hike.

- **Medical Mutual's underwriting has become more profitable.** A.M. Best, one of the world's leading insurance company analysts, noted recently that Medical Mutual's "underwriting results have outperformed the medical malpractice industry composite, as evidenced by its five-year average combined ratio before policyholder dividends of just over 100 percent." An insurer's underwriting profit or loss is expressed as the so-called *combined ratio* – and the lower the combined ratio, the more profitable the company's insurance business. Medical Mutual's combined ratio is low by industry standards and has dropped over the course of the past five years.

- **Medical Mutual's profitability compares very favorably to other insurers.** In 2001, the last year for which complete data is available, Medical Mutual had a "pretax return on revenue" of 9.7 percent. The composite for the entire medical malpractice industry showed a substantial loss of 13.3 percent for this measure. Another measure of profitability is the "return on policyholders' surplus." Again in 2001, the year for which complete data is available, Medical Mutual had a 1.8 percent return, but the entire industry lost 7.8 percent.

- **A.M. Best rates Medical Mutual "A-" (Excellent).** For 2003, Medical Mutual earned its fifth consecutive "A-" (Excellent) rating from A.M Best. Best's rating is based on a number of financial indicators, including a company's overall earnings, underwriting income, investment income, and capitalization.

- **Medical Mutual boasts of its own fiscal health.** In its October 2002 newsletter, Medical Mutual's Board Chairman Lewers touted the company's "A-" rating from Best and noted that "[t]his strong financial rating reflects our 'excellent capitalization, continued profitability and sound operating strategy.'" Also, less than a year ago, Medical Mutual's chairman bragged that, "Despite intense marketplace pressures, the evolving health care delivery system, and an unpredictable legal system, Medical Mutual is now stronger than ever. As other professional liability insurance companies have gone insolvent, our growth initiatives and sound management have enhanced our position and made us stronger." The company also noted that "A.M. Best views the ratings outlook as stable."

- **Recent investment losses represent a short-term drag on profitability.** Investment losses, and other market forces that have nothing to do with lawsuits by patients, are recognized by independent insurance experts as the cause for the recent rise in some malpractice insurance premium costs across the U.S. Medical Mutual's profits would have been considerably higher over the last two years if not for considerable investment losses. Indications of Medical Mutual's declining investment picture include: The company made $12.4 million in 2001 and 2002 on the operating side but posted $5.9 million in losses on the investment side. This resulted in a net decline in income of about $8 million in each of 2001 and 2002 over what was earned in 2000.

- **Overall, since 1996 Medical Mutual kept its rate increases for malpractice insurance well behind the rising cost of medical services.** When a representative "midpoint" premium (for general surgery) is tracked from 1996 through 2002, Medical Mutual's rates increased only 5.7 percent over six years, or less than 1 percent annually. When the value of the premium is adjusted for medical services inflation, the midpoint premium declined 15.9 percent – from $34,530 in 1996 to $29,042 in 2002. In equivalent dollars, a general surgeon paid Medical Mutual $5,488 *less* for malpractice coverage in 2002 than in 1996.

- **Medical Mutual's rates for general surgeons and obstetricians/gynecologists increased much slower than the cost of medical services.** From 1996 to 2002, Medical Mutual increased rates between 15.6 and 16.4 percent for general surgeons, and between 11.4 and 11.7 percent for obstetricians/gynecologists. During these years, the cost of medical services increased 25.8 percent.

- **Medical Mutual rates for internists increased slightly more than the cost of medical services.** From 1996 to 2002, Medical Mutual increased rates between 27.1 and 30.8 percent for doctors practicing internal medicine. During these years, the cost of medical services increased 25.8 percent.

- **Homeowners' insurance rates in Maryland have increased much faster than doctors malpractice insurance rates charged by Medical Mutual suggesting an insurance industry – not litigation – problem.** According to averages calculated by the Maryland Insurance Administration, rates for homeowners insurance increased by a cumulative 60.2 percent from 1996 to 2002, or 8.6 percent annually. During those same years, doctors covered by Medical Mutual of Maryland paid cumulative increases ranging from 11.4 percent to 30.8 percent, or between 1.6 percent and 4.4 percent annually.

- **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."

- **Nationwide health insurance costs have increased far more than Medical Mutual's rates.** The cost of health insurance premiums nationwide has increased by a cumulative 54 percent since 1997 – an average of 10.8 percent per year. During those same years, doctors covered by Medical Mutual of Maryland paid cumulative increases ranging from 11.4 percent to 30.8 percent, or only between 1.6 percent and 4.4 percent per year.

- **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.

Section III: Solutions to Reduce Medical Errors and Long-term Insurance Rates

- **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 their doctors. It 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.

Introduction

Medical Mutual is the largest malpractice insurer in Maryland, with 33.6 percent of the market.[1] According to the company's president, it insures about 80 percent of physicians in private practice.[2] And it has maintained a dominant market share for several years while avoiding sizeable increases in the rates it charges to physicians – most of whom are also its shareholders.

In August, the insurer was granted a rate hike of 28 percent – something that should concern health care providers and health care consumers alike, considering how much of the market is covered by Medical Mutual and how starkly this substantial rate increase contrasts with the company's pattern of modest increases since the mid-1990s.

The basis for Medical Mutual's 28 percent rate hike has been challenged by J. Robert Hunter, a knowledgeable insurance actuary and Director of Insurance for the Consumer Federation of American. He suggests a rate increase of up to five percent is warranted.

The rate request was accompanied by statements from Medical Mutual executives and representatives of the Maryland State Medical Society, known as MedChi, echoing the anti-patient, anti-consumer rhetoric heard during the national medical malpractice debate – that frivolous lawsuits and skyrocketing jury awards are to blame for rising costs of medical malpractice insurance.[3] In making these arguments, physicians and insurance companies are essentially blaming the victims – patients who have been injured by medical mistakes and neglect. And the remedies that these groups propose would hurt patients further, restricting the compensation they are allowed to be awarded.

Maryland already has enacted a $620,000 cap, no matter how severe the injury, on the amount that patients can receive for non-economic damages – the pain and suffering and loss of lifestyle associated with paralysis, severe brain damage, disfigurement, blindness and deafness, or loss of childbearing ability. Already, MedChi has begun calling for even further restrictions on patient compensation, including limits on economic damages.[4]

The importance of challenging claims made by the doctors' lobby is underscored by a recent General Accounting Office (GAO) report that found the American Medical Association (AMA) 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.[5]

Rather than reducing the real threats that medical care poses to their patients, the doctor's lobby would prefer to shift the costs of injuries onto individuals, their families, voluntary organizations and taxpayers. This is unfortunate. Doctors should join with patients and consumers in working to reform the business practices of the insurance industry, rather than blaming the victims and their lawyers; and to better police the very small number of their profession who commit most of the state's malpractice.

Section I

Lawsuits Are Not Responsible for Rising Medical Malpractice Insurance Premiums in Maryland

Patients and 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.[6] 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 Maryland should be measured by the cost to patients and consumers, not the premiums paid by doctors and other health providers to their insurance companies. Extrapolating from the IOM findings, we estimate that there are 836 to 1,862 preventable deaths in Maryland each year that are due to preventable medical errors. The costs resulting from preventable medical errors to Maryland's residents, families and communities is estimated at $323 million to $551 million each year. But the cost of medical malpractice insurance to Maryland's health care providers is only $155.1 million a year.[7] [See Figure 1]

Figure 1

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

836 – 1,862

Preventable Maryland Deaths Due to Medical Errors Each Year

$323 million – $551 million

Maryland Costs Resulting from Preventable Medical Errors Each Year

$155.1 million

Cost of Maryland Health Care Providers' Annual Medical Malpractice Premiums

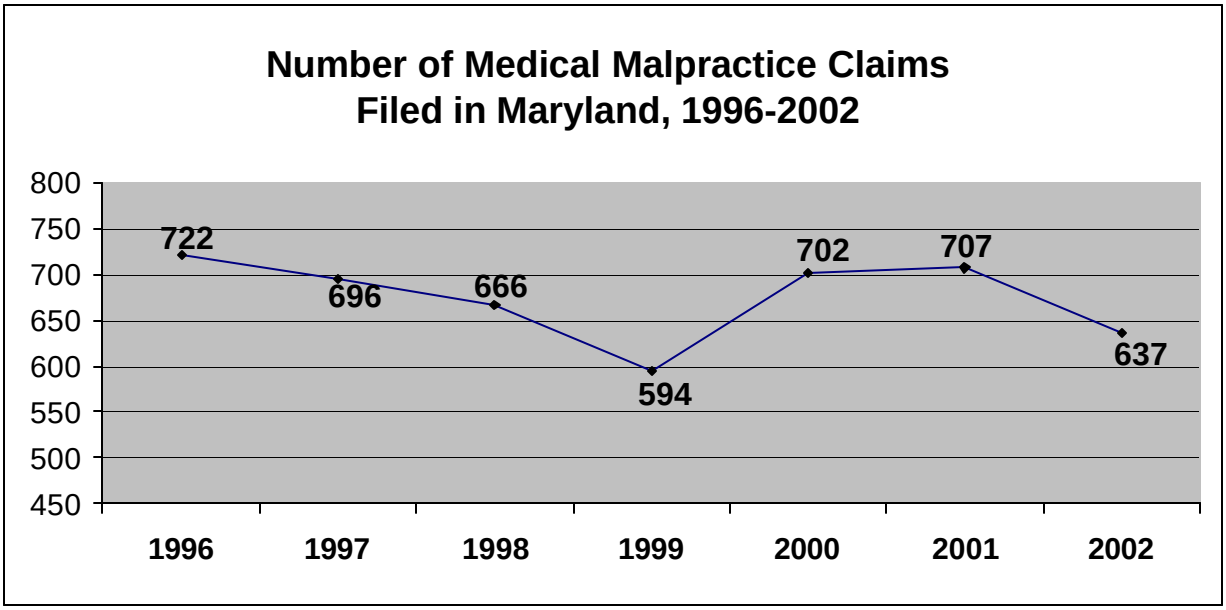
Sources: Preventable deaths and costs are prorated based on population and based on estimates in *To Err Is Human*, Institute of Medicine, November 2000. Malpractice premiums are based on "Medical Malpractice Net Premium and Incurred Loss Summary," National Association of Insurance Commissioners, July 18, 2001.

Medical Malpractice Insurers Benefit from Declining Claims in Maryland

In the national medical malpractice debate, proponents of tort law changes have claimed that increased litigation and jury awards have forced insurance companies to increase the medical liability insurance premiums they charge doctors. Less than a year ago, the chairman of Medical Mutual of Maryland echoed this rhetoric when he warned of "extreme pressure from skyrocketing jury awards."[8] What the chairman failed to note, however, is that Maryland state data show that the number of legal claims for medical malpractice has declined – not increased – since 1996.

- **The number of medical malpractice legal claims filed was 11.8 percent lower in 2002 than it was in 1996.** According to the Maryland Office of Health Claims Arbitration, which processes all medical malpractice claims exceeding $25,000, there were 722 claims filed in Maryland in 1996, compared with 637 in 2002 – a decline of 85 claims, or 11.8 percent [See Figure 2] In fact, the number of legal claims filed for medical malpractice in 2002 was lower than it had been in five of the preceding six years.

Figure 2



Source: Office of Health Claims Arbitration, State of Maryland, 2003.

- **Claims filed against Medical Mutual declined 11.5 percent from 1996 to 2001.** The company reported 506 claims filed against it 1996 and 448 claims in 2001, the most current data available.[9]

Figure 3

Number of Medical Malpractice Legal Claims Filed per 100 Physicians in Maryland, 1996-2002

	1996	1997	1998	1999	2000	2001	2002
Malpractice Claims	722	696	666	594	702	707	637
Claims per 100 Physicians	3.4	3.3	3.1	2.7	3.2	3.2	2.8

Sources: National Practitioner Data Bank, Jan. 1, 1996 – Dec. 31, 2002. Calculations based on Maryland Board of Physicians report as submitted to Federation of State Medical Boards Physician Population Survey, 1996-2002.

- **The number of medical malpractice legal claims filed per physician has dropped 17.6 percent since 1996.** In 1996, there were 3.4 legal claims for medical malpractice per 100 Maryland physicians, compared with 2.8 claims per 100 physicians in 2002. [See Figure 3] This is based on a physician population in Maryland of 20,994 in 1996 and 22,559 in 2002, as reported by the Maryland Board of Physicians.

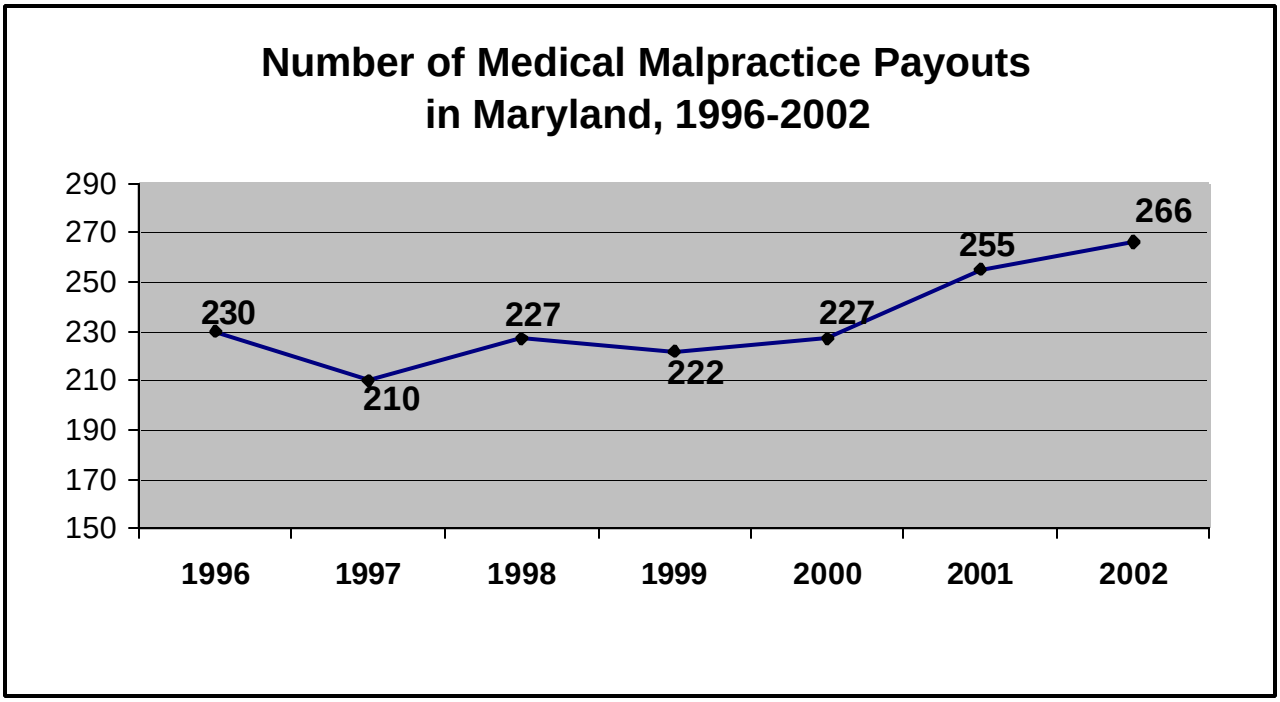
Number of Payouts for Medical Malpractice Has Remained Flat in Maryland

Federal government statistics contained in the National Practitioner Data Bank (NPDB) show no evidence that Maryland has experienced the sort of spike in medical malpractice payouts to injured patients that would justify a sharp increase in the premiums charged to physicians by Medical Mutual or other liability insurers. In fact, when measured against the growing physician population of the state, the rate of malpractice payouts has remained unchanged over the past seven years.

- **The number of medical malpractice payouts per Maryland physician has remained flat.** According to federal National Practitioner Data Bank data, in 1996, there were 230 medical malpractice payouts, and in 2002 there were 266 payouts – an increase of 15.6 percent, or 2.6 percent a year. [See Figure 4] But, this slight increase all but disappears when the growing number of doctors in the state is considered. There were 1.2 malpractice payouts per 100 Maryland physicians in 2002 – almost the same as the 1.1 ratio in 1996. [See Figure 5] Over the past six years, the number of malpractice payouts per 100 physicians has fluctuated in the very narrow range between 1.0 and 1.2.

- **Medicare's adjustment for the cost of malpractice insurance is lower for Maryland doctors than for doctors nationally.** A further indication that Maryland doctors are not unduly burdened by malpractice claims or malpractice costs can be found in the calculations by the federal Medicare actuary. According to the Medicare formula, Maryland doctors spend an average of only 2.4 to 2.9 percent of their practice incomes on malpractice insurance costs, compared with a national average of 3.2 percent.[10]

Figure 4



Source: National Practitioner Data Bank, Jan. 1, 1996 – Dec. 31, 2002.

Figure 5

Number of Medical Malpractice Payouts per 100 Physicians in Maryland, 1996-2002

	1996	1997	1998	1999	2000	2001	2002
Total Payouts	230	210	227	222	227	255	266
Payouts per 100 Physicians	1.1	1.0	1.0	1.0	1.0	1.1	1.2

Sources: National Practitioner Data Bank, Jan. 1, 1996 – Dec. 31, 2002. Calculations based on Maryland Board of Physicians report as submitted to Federation of State Medical Boards Physician Population Survey, 1996-2002.

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

Medical Mutual's 28 percent rate increase comes at the end of a six-year period when statewide payouts for medical malpractice grew much more slowly than the cost of medical services.

- **The total amount of malpractice payouts in Maryland dropped almost 18 percent from 1996 to 2002, after adjusting for inflation.** According to the federal National Practitioner Data Bank, malpractice payouts in 1996 totaled $71.3 million, compared with payouts of $73.6 million in 2002 – an increase of $2.3 million or only 3.2 percent over six years. [See Figure 6] However, malpractice payouts in Maryland declined 17.9 percent – from $71.3 million in 1996 to $58.5 million in 2002 – when the value of payouts is adjusted for medical services inflation. In equivalent dollars, liability insurers paid out $12.8 million *less* in 2002 than they paid out in 1996.

Figure 6

Total Medical Malpractice Payouts in Maryland v. Payouts Adjusted for Medical Services Inflation, 1996-2002

Year	Total Amount of Payouts	Total Payouts in 1996 Dollars (Adjusted for Medical Services Inflation Rate)
1996	$71.3 million	$71.3 million
1997	52.5 million	51.0 million
1998	57.1 million	53.7 million
1999	51.1 million	47.8 million
2000	62.5 million	54.6 million
2001	68.0 million	56.7 million
2002	73.6 million	58.5 million
$ Change (1996-2002)	**$2.3 million**	**- ($12.8 million)**
% Change (1996-2002)	**3.2%**	**- (17.9)%**

Sources: National Practitioner Data Bank, Jan. 1, 1996 – Dec. 31, 2002.
Bureau of Labor Statistics – Medical Services CPI.

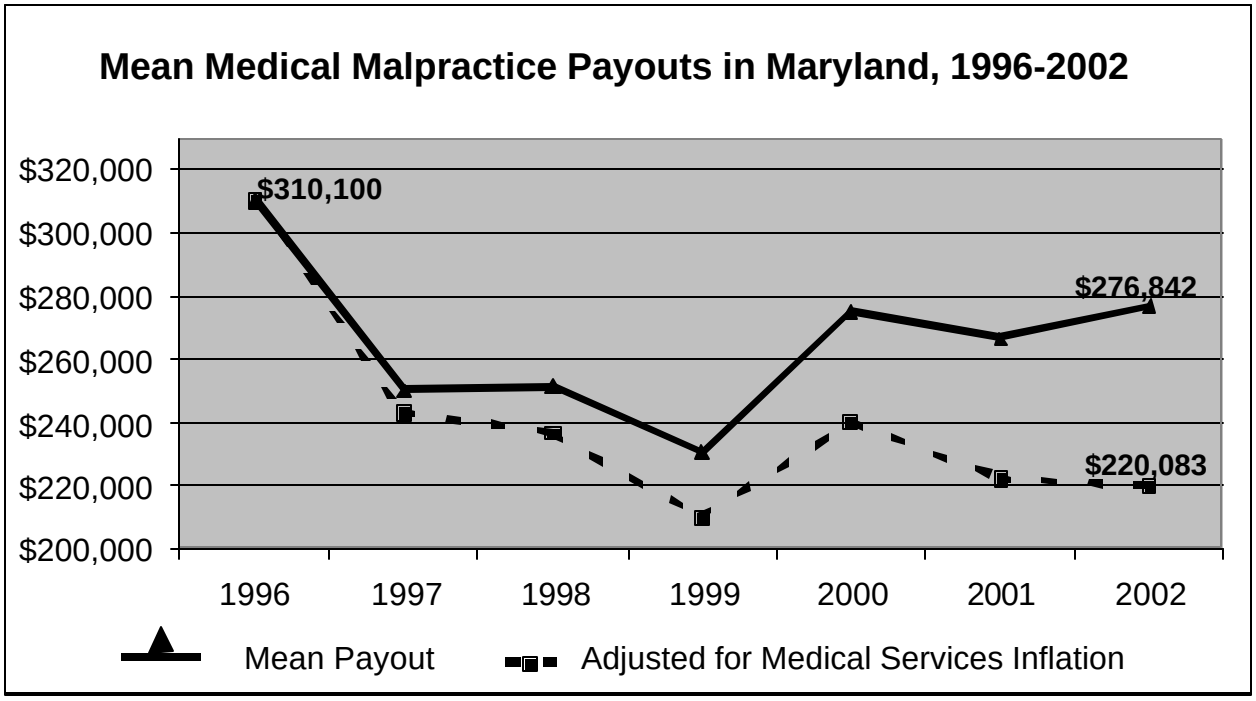
Mean Malpractice Payouts in Maryland Has Declined Substantially

In reaction to Medical Mutual's request for a 28 percent increase in rates, the Maryland State Medical Society, known as MedChi, quickly claimed that patient lawsuits and large payouts have pushed up the costs of malpractice insurance.

MedChi's executive director, T. Michael Preston – who also sits on Medical Mutual's board of directors – told the media, "What we're seeing is a growth in the multimillion dollar award, and it is those that drive the system."[11] And in similar fashion, Medical Mutual's president, David L. Murray, attempted to justify the rate increase by claiming that insurers are paying greater average amounts in malpractice cases.[12] Official data from the federal National Practitioner Data Bank, however, contradicts both assertions.

- **The mean medical malpractice payout in Maryland declined nearly 11 percent from 1996 to 2002.** NPDB data on payouts made to injured patients shows that the mean payout in 1996 was $310,100, compared with a mean of $276,842 in 2002 – a drop of $33,258 or 10.7 percent. [See Figure 7]

Figure 7

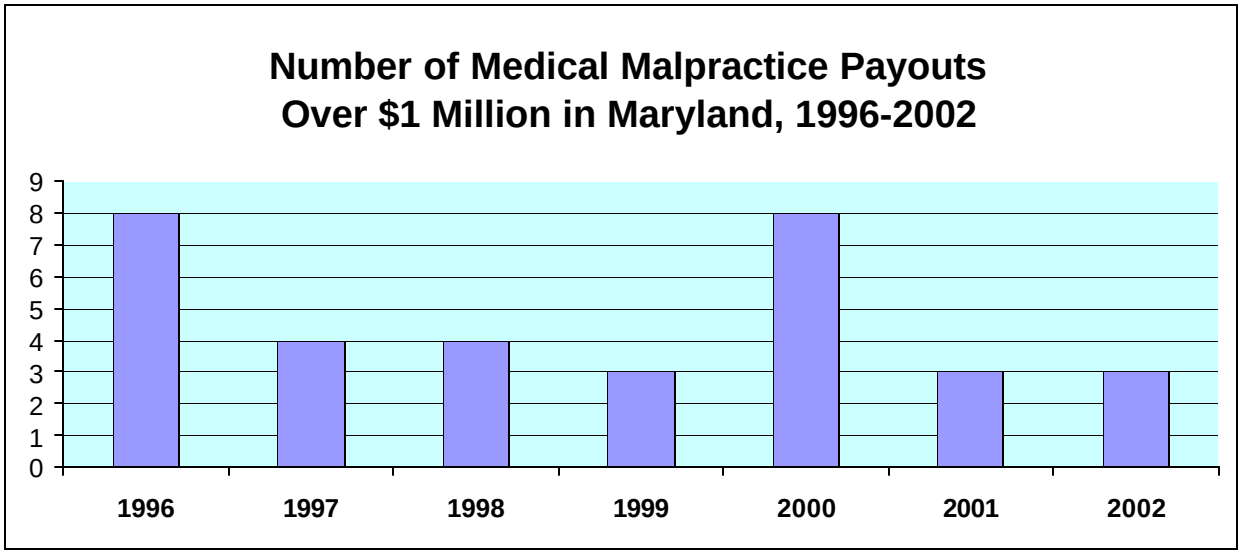


Sources: National Practitioner Data Bank, Jan. 1, 1996 – Dec. 31, 2002.
Bureau of Labor Statistics – Medical Services CPI.

- **Adjusted for the cost of medical services, the mean medical malpractice payout dropped 29 percent from 1996 to 2002.** The mean malpractice payout in Maryland dropped from $310,100 in 1996 to $220,083 in 2002 – a decline of 29 percent – when the value of payouts is adjusted for medical services inflation. In equivalent dollars, liability insurers made mean payouts that were $90,017 *less* in 2002 than in 1996. [See Figure 7]

- **There were only three medical malpractice payouts of $1 million in each of the past two years.** Contrary to claims from MedChi's executive director, NPDB data reveal that there has been no explosion of million-dollar malpractice payouts in Maryland. There were three such payouts reported in 2001 and three in 2002 – substantially fewer than the eight million-dollar payouts reported in 1996 and 2000. [See Figure 8] Moreover, the three million-dollar payouts in 2002 represent only 1 percent of the total number of payouts made that year.

Figure 8



Source: National Practitioner Data Bank, Jan. 1, 1996 – Dec. 31, 2002.

There Is No Evidence of a Doctor Exodus

MedChi officials responded quickly to Medical Mutual's 28 percent rate increase request with the dire warning that Maryland needs to impose stricter limits on malpractice compensation to patients or risk having many doctors quit their practices or leave the state.[13] Statistics reveal, however, that far from an "exodus" of doctors Maryland has experienced a steady increase in the number of doctors.

These statistics are reinforced by an August 2003 report from the General Accounting Office that debunked claims by the AMA and allied groups that fewer doctors were providing services in so-called medical malpractice "crisis states."[14] (See later section.)

- The number of resident doctors in Maryland has jumped by 1,565 since 1996, from 20,994 in 1996 to 22,559 in 2001. This is an overall increase of 7.5 percent, or 1.2 percent a year. [See Figure 9]

- Maryland had 38.2 doctors per 10,000 population in 2001, compared with a national average of 26.8 doctors per 10,000 population.[15] Maryland has the fourth highest ratio of doctors-to-population among all 50 states and Washington, D.C.

Figure 9

Licensed Physicians and Osteopaths in Maryland – 1996-2002

Year	Maryland Physicians
1996	20,994
1997	21,341
1998	21,537
1999	21,820
2000	21,779
2001	22,068
2002	22,559
Increase	**1,565** **7.4%**

Source: Maryland Board of Physicians, report submitted to Federation of State Medical Boards Physician Population Survey, 1996-2002.

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

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 Maryland.

- According to the federal government's National Practitioner Data Bank, which covers malpractice judgments and settlements since September 1990, just 3 percent of Maryland's doctors have been responsible for 50.8 percent of malpractice payouts to patients. [See Figure 10] Overall, these 576 doctors, all of whom have made two or more payouts, have paid $317.3 million in damages.

- Even more surprising, just 0.9 percent of Maryland doctors (180), each of whom has paid three or more malpractice claims, were responsible for 24.1 percent of all payouts.

- 89.4 percent of Maryland doctors have never made a malpractice payout.

Figure 10

Number of Medical Malpractice Payouts to Patients and Amounts Paid by Maryland Doctors, 1990-2002

Number of Payout Reports	Number of Doctors That Made Payouts	Percent/ Total Doctors (19,215)*	Total Number of Payouts	Total Amount of Payouts	Percent of Total Number of Payouts
All	2,037	10.6%	2,967	$653,453,300	100.0%
1	1,461	7.6%	1,461	$336,185,800	49.2%
2 or More	576	3.0%	1,506	$317,267,500	50.8%
3 or More	180	0.9%	714	$137,701,550	24.1%
4 or More	67	0.3%	375	$68,134,500	12.6%
5 or More	33	0.2%	239	$39,551,000	8.1%

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

* *Note:* Based on Maryland's population of doctors as calculated by the American Medical Association for 1995, the closest year for which such data is available to the mid-point of the period studied.

Doctors with Repeated Malpractice Claims Against Them Suffer Few Consequences

The Maryland Board of Physician Quality Assurance and the state's health care providers have been criticized in the media and by lawmakers for failing to rein in doctors who repeatedly commit medical errors and medical negligence.[16] According to the National Practitioner Data Bank and Public Citizen's analysis of NPDB data, Maryland doctors can make up to 10 malpractice payouts without facing more than a 50 percent chance that some disciplinary action (license suspension or revocation, or a limit on clinical privileges) will be taken against them. [See Figure 11]

- 14.1 percent (81 of 576) of Maryland doctors who made two or more malpractice payouts were disciplined by the Maryland Board of Physician Quality Assurance.[17]

- 20.6 percent (37 of 180) of Maryland doctors who made three or more malpractice payouts were disciplined by the board.

- 34.3 percent (23 of 67) of Maryland doctors who made four or more malpractice payouts were disciplined by the board.

- 42.4 percent (14 of 33) of Maryland doctors who made five or more malpractice payouts were disciplined by the board.

- Three of the six Maryland doctors who made 10 or more malpractice payouts (50 percent) were disciplined by the board.

Figure 11

Maryland Doctors with Two or More 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 Licensure Actions	Percentage of Doctors with One or More Licensure Actions
2 or More	576	81	14.1%
3 or More	180	37	20.6%
4 or More	67	23	34.3%
5 or More	33	14	42.4%
10 or More	6	3	50.0%

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

Where's the Doctor Watchdog?

Opportunities for Maryland to cut its rate of malpractice claims by reducing the frequency of medical errors and negligence have been undercut by the Maryland Board of Physician Quality Assurance's failure to diligently discipline doctors who commit repeated malpractice.

The board's poor performance, in fact, provoked the 2003 Maryland Legislature to create a new State Board of Physicians that will have slightly wider latitude in deciding on disciplinary actions and will be less reliant on the state medical society, MedChi, to perform investigations.[18] The chief lobbyist for MedChi, however, received public credit from the doctors' group for fighting off several reforms that would have made the disciplinary process any more stringent.[19]

A 2000 study by the state's Office of Legislative Audits found that the state Board of Quality Assurance failed to take action on 140 of 493 complaints against doctors within four years of receiving those complaints.[20] This was among the shortcomings that prompted lawmakers to seek improvements in the physician discipline process – an effort that failed in 2002 after heavy lobbying by MedChi.[21] This led one frustrated legislator to complain to the media that the Board of Quality Assurance "is very geared toward doing nothing."[22]

A bill reforming doctor discipline finally passed the Maryland Legislature in 2003, but only after MedChi prevented the state from adopting the standard of a "preponderance of evidence" in most investigations – a standard that the Federation of State Medical Boards says is used in two-thirds of all states.[23] The state will continue to judge doctors by the harder-to-prove standard of "clear and convincing evidence" in all cases except those involving non-medical transgressions, such as drug offenses or assaults.[24]

- **The Maryland Board of Quality Assurance has been among the nation's least diligent when it comes to disciplining doctors.** In 2002, Maryland ranked 46th among all states and the District of Columbia for the frequency at which it takes serious disciplinary actions against doctors for incompetence, misprescribing drugs, sexual misconduct, criminal convictions, ethical lapses or other offenses. In 2002, the Maryland Board of Physician Quality Assurance levied serious sanctions against only 39 of its 21,833 doctors, according to Public Citizen's Health Research Group ranking of the rate of state medical boards' serious disciplinary actions in 2002.[25]

  Nationally in 2002, there were 3.6 serious actions taken for every 1,000 physicians. The rate of serious actions by the Maryland board were half that – 1.8 per 1,000 physicians – and was roughly one-sixth of the rate in Wyoming, which is the top-ranked state with 11.9 serious actions per 1,000 physicians.[26]

  Over the past decade, Maryland has descended sharply in its rate of doctor discipline, from its best ranking of 19th in 1993 to its worst ranking of 46th in 2002. In seven of the last 10 years, Maryland has been rated in the bottom half of all states.

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

In recent months, MedChi has made claims that Maryland doctors are about to face a medical malpractice crisis and that the health of Maryland 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.[27] Ironically, the report was requested by three Republican House committee chairs who support restricting patients' legal rights in malpractice cases.

Congressional lawmakers earlier this year 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.

- The overall number of doctors in the AMA-designated "crisis states" had not declined, echoing findings made by Public Citizen in reports on medical malpractice conditions in states released earlier this year.[28]

- The AMA's claims that medical services were unavailable in particular areas were untrue. 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."[29]

- "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."[30]

- "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."[31]

- Job actions by the AMA, its state affliates, 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 noneconomic damages for malpractice cases at $250,000 was not passed."[32]

- 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."[33]

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

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

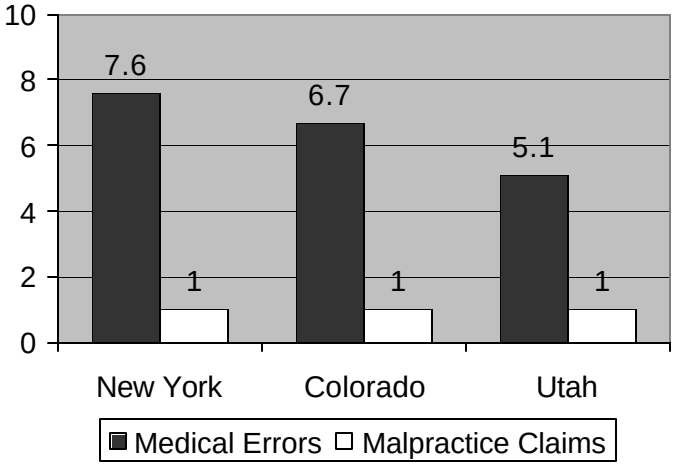
- **A landmark Harvard Medical Practice Study found that only a small percentage of medical errors result in lawsuits.** Twelve years ago, Harvard researchers using a sample of hospitalizations in New York State compared medical records to claims files. They found that only one in 7.6 instances of medical negligence committed in hospitals results in a malpractice claim.[34] Researchers replicating this study made similar findings in Colorado and Utah.[35] [See Figure 12]

- **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.[36] In other words, for every six preventable medical errors only one claim is filed. [See Figure 13]

- **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.[37] The increase in this expense is noticeable primarily because of the decreases in reimbursements that doctors are receiving from HMOs and government health programs.

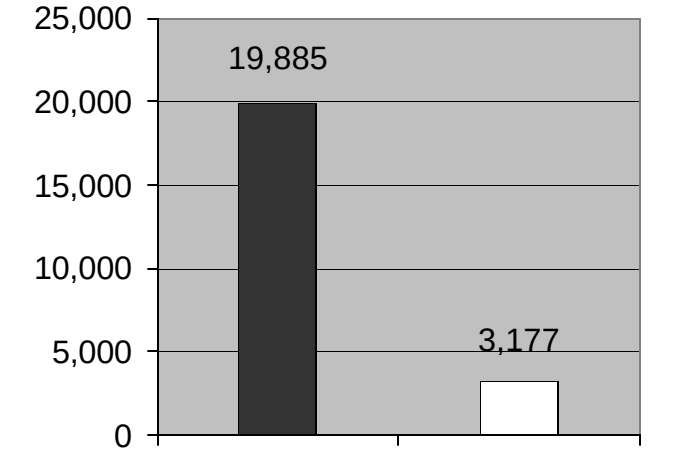
- **The compensation gap helps explain why, although medical injuries are costly, expenditures on medical liability comprise less than 1 percent of overall health care costs.** As the Congressional Budget Office reported, "Malpractice costs account for a very small fraction of total health care spending; even a very large reduction in malpractice costs would have a relatively small effect on total health plan premiums. In addition, some of the savings leading to lower medical malpractice premiums—those savings arising from changes in the treatment of collateral-source benefits—would represent a shift in costs from medical malpractice insurance to health insurance."[38]

Figure 12
Malpractice Claims Gap:
Ratio of Medical Errors to Claims Filed



Source: Harvard Medical Practice Study Group, *Patients, Doctors and Lawyers: Medical Injury, Malpractice Litigation, and Patient Compensation in New York* (1990); Studdert et al, "Beyond Dead Reckoning: Measures of Medical Injury Burden, Malpractice Litigation, and Alternative Compensation Models from Utah and Colorado," 33 Ind. L. Rev. 1643 (2000).

Figure 13
Florida Malpractice Claims Gap: 1996-1999
Ratio of Medical Errors to Claims Filed



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

Few Malpractice Lawsuits Are "Frivolous"

When Medical Mutual of Maryland filed for its 2003 rate increase, the company and members of the state medical society, known as MedChi, were quick to blame the rising cost of malpractice insurance premiums on so-called "frivolous" lawsuits brought by patients.[39]

President Bush and some members of the U.S. Senate and House have made similar comments about "frivolous lawsuits" in their efforts to promote a federal medical malpractice bill that would place caps on pain-and-suffering awards to injured patients.[40]

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.[41] If the case goes to trial, the costs can easily be doubled.[42] 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.[43] 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.[44] 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. 4600. This bill, which contained very stringent restrictions on patients' ability to recover damages, passed the U.S. House in 2002. CBO declined, saying:

  > Estimating the amount of health care spending attributable to defensive medicine is difficult. Most estimates are speculative in nature, relying, for the most part, on surveys of physicians' responses to hypothetical clinical situations, and clinical studies of the effectiveness of certain intensive treatments. Compounding the uncertainty about the magnitude of spending for defensive medicine, there is little empirical evidence on the effect of medical malpractice tort controls on spending for defensive medicine and, more generally, on overall health care spending.
  >
  > A small number of studies have observed reductions in health care spending correlated with changes in tort law, but that research was based largely on a narrow part of the population and considered only hospital spending for a small number of ailments that are disproportionately likely to experience malpractice claims. Using broader measures of spending, CBO's initial analysis could find no statistically significant connection between malpractice tort limits and overall health care spending. Although the provisions of H.R. 4600 could result in the initiation of fewer lawsuits, the economic incentives for individual physicians or hospitals to practice defensive medicine would appear to be little changed.[45]

- **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."[46]

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."[47]

- **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.[48] There were nine such instances in Florida in 2001.[49] 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.[50] 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."[51]

- **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.[52] 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."[53] 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"?[54] Previously, consultants retained by medical provider groups have argued that medical providers *overspend* on precautionary measures by five to nine percent.[55]

- **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.[56] One report found specifically that each additional patient per nurse corresponded to a 7 percent increase in both patient mortality and deaths following complications.[57] Nevertheless, nursing shortages persist, even though the defensive medicine theory predicts over-staffing.

Section II

Medical Mutual's 28 Percent Rate Increase Is Not Justified

Medical Mutual Is Very Profitable and in "Excellent" Financial Condition

Medical Mutual's 28 percent rate increase is not justified by the company's recent strong profitability. In fact, over the last five years Medical Mutual's insurance business has gotten more profitable each year, and was more profitable in 2002 than in each of the previous four years (when it also was very profitable).

- **The 28 percent rate increase approved for Medical Mutual is excessive.** J. Robert Hunter, current Director of Insurance for the Consumer Federation of America, and former Texas insurance commissioner and Federal Insurance Administrator, closely examined Medical Mutual's 28 percent rate increase request. He has concluded that "there should be only a very minor increase, of the order of 2.5% to 5.0%."[58] Among other things, Hunter finds that Medical Mutual's rate filing increase is faulty because the company proposes to "vastly over-reserve" to cover future payouts, overstates how much large payouts are increasing, and "vastly understates investment income potential of the [company's] reserves."

- **Medical Mutual provided a 21 percent rate discount to policyholders in 2003.** As evidence of its strong profit position and overall financial health, Medical Mutual provided a 21 percent "Tort Reform Dividend Credit" for all policyholders renewing in 2003. As the company noted in October 2002, "This tort reform dividend credit is the positive result of our aggressive advocacy efforts on behalf of Maryland Physicians. As a mutual company, these additional savings are returned to our Insureds in dividend credits. This is the 14th consecutive year we will be returning a Tort Reform Dividend Credit."[59] Over the last five years, Medical Mutual's returned dividends to policyholders averaged 27.2 percent a year or more than 27 cents on each dollar paid in premiums.[60]

  Indicating that Medical Mutual has not been affected by the legal environment, Board Chairman Dr. Ted Lewers noted nine months ago that "We are especially pleased that Medical Mutual is able to return this dividend at a time when the nation's medical professional liability environment is under extreme pressure from skyrocketing jury awards."[61] Moreover, Lewers did not suggest that there was a deteriorating medical liability climate in Maryland.

  Although there does not appear to be any justification for a rate increase, it certainly could be avoided if Medical Mutual decided to forgo policyholders' dividend rebates, which closely approximate the requested rate hike.

- **Medical Mutual's underwriting has become more profitable.** Despite the annual sizable dividend returns to policyholders, A.M. Best, one of the world's leading insurance company analysts, noted recently that Medical Mutual's "underwriting results have outperformed the medical malpractice industry composite, as evidenced by its five-year average combined ratio before policyholder dividends of just over 100 percent."[62]

An insurer's underwriting profit or loss is expressed as the so-called *combined ratio.* This measure shows the profitability of a given line of policies and reveals the amount of premium-related expenses paid out per year (including dividends paid) versus the amount received in premiums. The lower the combined ratio, the more profitable the company's insurance business.

Medical Mutual's combined ratio is low by industry standards and has dropped over the course of the past five years – from 131.4 in 1998 to 121.1 in 2002. [See Figure 14] In other words, for every one dollar collected in premiums the company paid out or put into reserves $1.31 in 1998, but it only paid out or put into reserves $1.21 in 2002. This decline of 10 cents in payouts and reserves for each premium dollar indicates that Medical Mutual performed better on the underwriting portion of its business last year than it did in 1998. Medical malpractice insurers typically pay out and place into reserves quite a bit more than they take in because they maintain high loss reserves in order to adequately address losses that present themselves over a course of several years.

The combined ratio for Medical Mutual is considerably less than $1.21 per premium dollar, when one deducts the amount that the company rebates in dividends to policyholders each year. For instance, in 2002 the combined ratio minus dividends is about 100 percent – 121.1 minus a 20.8 percent dividend rebate to policyholders. Given the expectation of significant investment earnings, a medical malpractice insurer with a 100 percent combined ratio is considered very profitable.

As A.M. Best noted, "Sizeable policyholder dividends, which have averaged nearly 25 percent of net premiums earned over the five year period, as well as the treatment of the rate stabilization fee … have dampened net underwriting results."[63]

Figure 14

Profitability of Medical Mutual of Maryland, Combined Ratio v. Combined Ratio Minus Dividend 1998-2002

Year	Combined Ratio	Combined Ratio, Minus Dividend
1998	131.4	96.0
1999	131.3	101.5
2000	126.7	96.9
2001	121.6	100.1
2002	121.1	100.3

Source: "Financial Performance," *Best's Rating and Report Updates for Medical Mutual Liability Ins. Soc. of Md.*, at www.ambest.com, June 8, 2003.

- **Medical Mutual's profitability compares very favorably to other insurers.** In 2001, the last year for which complete data is available, Medical Mutual had a "pretax return on revenue" of 9.7 percent. The composite for the entire medical malpractice industry showed a substantial loss of 13.3 percent for this measure.[64]

  Another measure of profitability is the "return on policyholders' surplus." This is the investment return on the money the company receives from shareholders at the beginning of the year when premiums are paid, which it then temporarily invests. Again in 2001, the year for which complete data is available, Medical Mutual had a 1.8 percent return, but the entire industry lost 7.8 percent.[65]

Medical Mutual and Independent Analysts Agree – the Company Is Financially Strong

Independent insurance company analysts and Medical Mutual's own claims indicate the company is financially healthy, raising serious questions about whether the 28 percent hike is deserved or simply a ploy to pass legislation reducing the liability of its shareholders – Maryland doctors – for medical negligence.

- **A.M. Best rates Medical Mutual "A-" (Excellent).** For 2003, Medical Mutual earned its fifth consecutive "A-" (Excellent) rating from A.M Best.[66] Best's rating is based on a number of financial indicators, including a company's overall earnings, underwriting income, investment income, and capitalization.

- **Medical Mutual's claims of fiscal health.** In its October 2002 newsletter, Medical Mutual's Board Chairman Lewers touted the company's "A-" (Excellent) rating from Best and noted that "[t]his strong financial rating reflects our 'excellent capitalization, continued profitability and sound operating strategy.'" In summary, the newsletter noted that with its "'excellent capitalization and strong balance sheet position, A.M. Best views the rating outlook as stable.'"[67] Nine months later Medical Mutual filed for the 28 percent rate hike.

  Also in 2002, Medical Mutual bragged that, "Despite intense marketplace pressures, the evolving health care delivery system, and an unpredictable legal system, Medical Mutual is now stronger than ever. As other professional liability insurance companies have gone insolvent, our growth initiatives and sound management have enhanced our position and made us stronger."[68]

Recent Investment Losses Represent a Short-Term Drag on Profitability

Investment losses, and other market forces that have nothing to do with lawsuits by patients, are recognized by independent insurance experts as the cause for the recent temporary rise in rates by medical malpractice insurance companies across the U.S.

- **Medical Mutual's investment losses have been considerable over the last two years.** Medical Mutual's profits would have been considerably higher over the last two years if not for considerable investment losses. The company made $12.4 million in 2001 and 2002 on the operating side but posted $5.9 million in losses on the investment side. [See Figure 15] This resulted in a net decline in income of about $8 million in each of 2001 and 2002 over what was earned in 2000. Since 2001, overall Medical Mutual earnings "have been adversely impacted by realized capital losses on its equity and fixed income portfolios," according to A.M. Best.[69] This decline in investment income has been due to declining interest rates, which limit returns on government and corporate bonds. Medical Mutual also sold its entire stock portfolio to limit its exposure due to the market decline of the past few years.[70]

Figure 15

Capital Generation Analysis, Medical Mutual of Maryland, 2000-2002

($000)

Year	Pretax Operating Income	Total Investment Gains	Net
2000	$7,602	$3,531	$11,133
2001	$7,334	-$(4,181)	$3,153
2002	$5,068	-$(1,762)	$3,306

Source: "Capital Generation Analysis," *Best's Rating and Report Updates for Medical Mutual Liability Ins. Soc. Of Md*, at www.ambest.com, June 8, 2003, p. 7.

Medical Mutual's Rate Increases Trailed Inflation

Medical Mutual grew during the 1990s – and it did so while generally keeping its rate increases well below the rising costs of medical care. The cost of medical services constitutes the lion's share of compensation paid in medical malpractice cases.

Since 1997, Medical Mutual bolstered its annual "net premiums earned" from $53.8 million to $70 million.[71] Now, in stark contrast with its modest price increases during those high-growth years, the company imposed a 28 percent rate increase on the physicians it covers.

- **Overall, since 1996 Medical Mutual kept its rate increases for malpractice insurance well behind the rising cost of medical services.** When a representative "midpoint" premium is tracked (for general surgery) from 1996 through 2002, Medical Mutual's rates increased only 5.7 percent over six years, or less than 1 percent annually. [See Figure 16] When the value of the premium is adjusted for medical services inflation, the midpoint premium declined 15.9 percent – from $34,530 in 1996 to $29,042 in 2002.[72] In equivalent dollars, a general surgeon paid Medical Mutual $5,488 *less* for malpractice coverage in 2002 than in 1996.

- **Medical Mutual's rates for general surgeons and obstetricians/ gynecologists increased much slower than the cost of medical services.** From 1996 to 2002, Medical Mutual increased rates (in the three Maryland regions for which it sets different premiums) by 15.6 to 16.4 percent for general surgeons, and by 11.4 to 11.7 percent for obstetricians/gynecologists. During these years, the cost of medical services increased by 25.8 percent. [See Figures 17 and 8]

- **Medical Mutual's rates for internists increased slightly more than the cost of medical services.** From 1996 to 2002, Medical Mutual increased rates (in the three Maryland regions for which it sets different premiums) by 27.1 to 30.8 percent for doctors practicing internal medicine. During these years, the cost of medical services increased 25.8 percent. [See Figure 19]

Figure 16

Midpoint Premiums Charged by Medical Mutual of Maryland v. Premiums Adjusted for Medical Services Inflation 1996-2002

Year	Midpoint Premiums*	Midpoint Premiums in 1996 Dollars (Adjusted for Medical Services Inflation Rate)
1996	$34,530	$34,530
1997	31,499	30,611
1998	29,526	27,779
1999	30,362	27,655
2000	32,429	28,315
2001	36,532	30,443
2002	36,532	29,042
$ Chg. 1996-2002	**$2,002**	**- ($5,488)**
% Chg. (1996-2002)	**+ 5.7%**	**- (15.9)%**

Sources: Premium amounts from *Medical Liability Monitor*, "Trends in Rates for Physicians' Medical Professional Liability Insurance," 1996-2002 editions as reported by Medial Mutual of Maryland. Inflation rate for medical services from Bureau of Labor Statistics – Medical Services CPI.

* *Note on methodology:* This comparison uses the premium charged by Medical Mutual in its middle-priced region for its middle-priced specialty, as reported each year in the *Medical Liability Monitor.* Medical Mutual divides Maryland into three pricing regions – Baltimore and Baltimore County (the highest priced); Montgomery, Prince George's, Howard and Anne Arundel counties (the middle priced); and the remainder of the state (the lowest priced). *Medical Liability Monitor* publishes rates for three specialties – internal medicine (the lowest rate); general surgery (the middle rate) and ob/gyn (the highest rate). In all instances, the midpoint premium reflects the rate charged for general surgery. In six of the seven years, the midpoint region was Montgomery, Prince George's, Howard and Anne Arundel counties.

Figure 17

Malpractice Rate Increases by Medical Mutual of Maryland for General Surgery (by Region) v. Medical Services Inflation 1996-2002

Year	Baltimore, Baltimore Co.	Montgomery, Pr. George's, Howard, Anne Arundel Counties	Remainder of State	Medical Services Inflation Rate (Year Over Year)
1996	- (7.2)%	n/a	n/a	3.8%
1997	0	0	0	2.9%
1998	- (6.1)%	- (6.1)%	- (6.1)%	3.3%
1999	7.0%	2.8%	2.9%	3.3%
2000	6.8%	6.8%	6.3%	4.3%
2001	12.6%	12.6%	12.6%	4.8%
2002	0	0	0	4.8%
Chg.* (1996-2002)	**16.4%**	**16.2%**	**15.6%**	**25.8%**

Figure 18

Malpractice Rate Increases by Medical Mutual of Maryland for Ob/Gyn (by Region) v. Medical Services Inflation 1996-2002

Year	Baltimore, Baltimore Co.	Montgomery, Pr. George's, Howard, Anne Arundel Counties	Remainder of State	Medical Services Inflation Rate (Year Over Year)
1996	0	n/a	n/a	3.8%
1997	0	0	0	2.9%
1998	0	0	0	3.3%
1999	2.9%	2.9%	2.9%	3.3%
2000	6.1%	6.0%	5.8%	4.3%
2001	2.3%	2.3%	2.3%	4.8%
2002	0	0	0	4.8%
Chg.* (1996-2002)	**11.7%**	**11.6%**	**11.4%**	**25.8%**

Figure 19

Malpractice Rate Increases by Medical Mutual of Maryland for Internal Medicine (by Region) v. Medical Services Inflation 1996-2002

Year	Baltimore, Baltimore Co.	Montgomery, Pr. George's, Howard, Anne Arundel Counties	Remainder of State	Medical Services Inflation Rate (Year Over Year)
1996	0	N/a	n/a	3.8%
1997	0	0	0	2.9%
1998	0	0	0	3.3%
1999	2.6%	2.6%	2.6%	3.3%
2000	13.1%	12.2%	9.9%	4.3%
2001	12.6%	12.6%	12.6%	4.8%
2002	0	0	0	4.8%
Chg.* (1996-2002)	**30.8%**	**29.7%**	**27.1%**	**25.8%**

Sources for Figures 17-19: Rate increases from *Medical Liability Monitor*, "Trends in Rates for Physicians' Medical Professional Liability Insurance," 1996-2002 editions. Inflation rate for medical services from Bureau of Labor Statistics – Medical Services CPI.

* *Note:* Cumulative changes reflect actual dollar amounts charged from 1996 to 2002 rather than a sum of annual percentages. The 1996 percentage change shown for Baltimore and Baltimore County reflects the change from 1995 to 1996. No 1995 data is available for the other regions, but the trend for all three regions appears to be nearly the same for the years 1996-1999.

Maryland Homeowners' Insurance Rates Have Risen Much Faster than Medical Mutual's Rates

Doctors and insurance companies insist that lawsuits and verdicts have spurred increases in malpractice insurance premiums. In reality, malpractice premiums have increased for the same reasons that the costs of many insurance products have increased. After years in which their bond portfolios and stocks registered healthy gains, and rates were lowered to attract customers and cash flow, the insurance industry now is suffering from poor investment returns.

In fact, consumers who pay homeowners' insurance in Maryland have faced much steeper rate increases since 1996 than doctors buying malpractice insurance from Medical Mutual of Maryland. According to averages calculated by the Maryland Insurance Administration, rates for homeowners insurance increased by a cumulative 60.2 percent from 1996 to 2002, or 8.6 percent annually.[73] [See Figure 20] During those same years, doctors covered by Medical Mutual of Maryland paid cumulative increases ranging from 11.4 percent to 30.8 percent, or between 1.6 percent and 4.4 percent annually. [Figures 17-19]

Figure 20

Rate Increases in Maryland Homeowners' Insurance, 1996-2002

Year	Weighted Average Change
1996	7.7%
1997	5.5%
1998	1.5%
1999	4.8%
2000	5.8%
2001	8.3%
2002	15.7%
Cumulative Increase	**60.2%**

Source: "Homeowners Insurance Summary of Rate Changes, Weighted Average Change," Maryland Insurance Administration.

Nationwide Health Insurance Costs Have Increased Far More than Medical Mutual's Rates

No consumer or professional welcomes rising insurance costs – and Maryland's doctors have pointed with alarm to recent increases in their medical malpractice insurance premiums. But the rates these doctors pay for their liability coverage have risen far slower than the rates that most patients (and those patients' employers) have paid for health insurance coverage in recent years.

In fact, the cost of health insurance premiums nationwide has increased by a cumulative 54 percent since 1997 – an average of 10.8 percent per year.[74] [See Figure 21] During those same years, doctors covered by Medical Mutual of Maryland paid cumulative increases ranging from 11.4 percent to 30.8 percent, or only between 1.6 percent and 4.4 percent per year. [See Figures 17-19]

Figure 21

Nationwide Increases in Health Insurance Premiums, 1997-2002

Year	Cost of Health Insurance Premium, Single Coverage	Annual Change
1997	$2,196	* * *
1998	2,268	3.3%
1999	2,424	6.9%
2000	2,650	9.3%
2001	3,060	15.5%
2002	3,383	10.6%
Cumulative Increase	**$1,187**	**54.0%**

Source: Kaiser Family Foundation and Health Research and Educational Trust, "Employer Health Benefits, Annual Surveys, 1998-2003."

Medical Mutual's Premium Spike Is Most Likely Caused by the Insurance Cycle Not the Legal System

If Medical Mutual is justified in getting some rate increase it is due to the company's modest rate increases in previous years, which did not keep pace with inflation, and the company's poor performing investments and the economics of the insurance cycle, rather than the legal system. However, Medical Mutual appears much better positioned than most insurance carriers, which have lost money from the insurance cycle.

- **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."[75]

- **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.[76] 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.[77]

- **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."[78] 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."[79]

- **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."[80]

- **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."[81] 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."[82]

  "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."[83]

Section III

Solutions to Reduce Medical Errors and Long-term Insurance Rates

Caps on Damages Are a False "Solution"

Maryland currently has a $620,000 cap on "non-economic damages" – also known as awards for pain and suffering – but the state doctors' lobby this year has begun advocating even further restrictions on patient compensation.[84] A $250,000 limit on non-economic damages is included in a bill that already has passed the U.S. House of Representatives, but was defeated in the U.S. Senate. There is convincing evidence, however, that limits on awards for pain and suffering penalize severely injured patients the most, without cutting the frequency of medical errors or reducing the rates doctors pay for liability insurance.

- **"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.[85] 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.[86] PIAA, as do most researchers, measures severity of injury according to the National Association of Insurance Commissioners' classifications.[87] 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.[88]

- **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[89]

"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[90]

"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[91]

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.[92]

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.[93]

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[94]

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.[95]

"[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[96]

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."[97]

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."[98]

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.[99]

"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[100]

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[101]

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. Medical Mutual of Maryland has 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, Maryland'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.[102]

  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,[103] 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. Maryland is ranked 46th among the 50 states and the District of Columbia for the number of serious actions taken per 1,000 physicians. (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.[104] Recent studies show that computer physician order entry (CPOE) systems can reduce error rates by 55 percent,[105] 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.[106]

- **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.[107]

- **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.[108] 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.[109] 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.[110] 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.[111] After 24 hours of wakefulness, cognitive function deteriorates to a level equivalent to having a 0. 10 percent blood alcohol level.[112] 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.[113] 45 percent of residents who sleep less than four hours per night report committing medical errors.[114] 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.[115] 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:[116]

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.**

Endnotes

[1] "Market Share and Loss Ratio," Maryland Insurance Administration, April 2003.
[2] Greg Garland, "28% Rise Sought to Insure Doctors," *Baltimore Sun*, June 28, 2003.
[3] *Id*.
[4] *Id*.
[5] United States General Accounting Office, Report GAO-03-836, "Medical Malpractice: Implications of Rising Premiums on Access to Health Care," August 2003. Available at http://www.gao.gov/new.items/d03836.pdf.
[6] *To Err Is Human, Building a Safer Health System*, Institute of Medicine, 2000, p. 26-27.
[7] "Medical Malpractice Net Premium and Incurred Loss Summary," National Association of Insurance Commissioners, July 18, 2001.
[8] Dr. Ted Lewers, "Notes from the Chair of the Board," newsletter of the Medical Mutual Liability Insurance Society of Maryland, October 2002.
[9] Medical Mutual Liability Insurance Society of Maryland, rate filing to Maryland Insurance Administration, Exhibit 2c, "Basic Limits Severity Trend Analysis," June 27, 2003.
[10] "Revisions to Payment Policies Under the Physician Fee Schedule for Calendar Year 2003 and Inclusion of Registered Nurses in the Personnel Provision of the Critical Access Hospital Emergency Services Requirement for Frontier Areas and Remote Locations," 67 Federal Register 80171, Dec. 31, 2002.
[11] Greg Garland, "28% Rise Sought to Insure Doctors," *Baltimore Sun*, June 28, 2003.
[12] *Id*.
[13] *Id*.
[14] United States General Accounting Office, Report GAO-03-836, "Medical Malpractice: Implications of Rising Premiums on Access to Health Care," August 2003. Available at http://www.gao.gov/new.items/d03836.pdf.
[15] Calculation based on American Medical Association, "Physicians Professional Data," as of 2001, copyright 2002; 2001 civilian population statistics from "Annual Population Estimates by State," July 1, 2001 Population, U.S. Census Bureau, available at http://eire.census.gov/popest/data/states/tables/ST-EST2002-01.php .
[16] Greg Garland, "Medical Board Backs Reforms / Nonpunitive System for Reporting Errors Gets Panel's Support," *Baltimore Sun*, Sept. 9, 2001. See also: Stephanie Desmon, "Medical Reform Locked in Fight," *Baltimore Sun*, March 17, 2003.
[17] National Practitioner Data Bank, public use files, Sept. 1, 1990 – Dec. 31, 2002.
[18] Stephanie Desmon, "Accord Reached on Doctor-Discipline Bill," *Baltimore Sun*, April 1, 2003.
[19] John O'Connor, "MedChi, Liquor Store Lobbyist Has Successful General Assembly Session," *Daily Record*, April 11, 2003.
[20] David Snyder and Jo Becker, "Md. Lawmakers Take Aim at Medical Board," *Washington Post*, March 21, 2003.
[21] *Id.*.
[22] *Id*.
[23] Stephanie Desmon, "Medical Reform Locked in Fight," *Baltimore Sun*, March 17, 2003.
[24] "New Maryland Health Care Legislation Takes Effect," *Daily Record*, June 20, 2003.
[25] Sidney Wolfe, M.D., "Public Citizen's Health Research Group Ranking of the Rate of State Medical Boards' Serious Disciplinary Actions in 2002," March 27, 2003. Available on Public Citizen's website at http://www.questionabledoctors.org/.
[26] *Id*.
[27] United States General Accounting Office, Report GAO-03-836, "Medical Malpractice: Implications of Rising Premiums on Access to Health Care," August 2003. Available at http://www.gao.gov/new.items/d03836.pdf.
[28] Public Citizen reports available at http://www.medicalmalpracticefacts.org.
[29] United States General Accounting Office, Report GAO-03-836, "Medical Malpractice: Implications of Rising Premiums on Access to Health Care," August 2003, p. 17. Available at http://www.gao.gov/new.items/d03836.pdf.
[30] *Id.*, p. 18.
[31] *Id.*, p. 18.
[32] *Id*., p. 13-14.
[33] *Id*., p. 20.
[34] Harvard Medical Practice Study Group, *Patients, Doctors and Lawyers: Medical Injury, Malpractice Litigation, and Patient Compensation in New York*, 1990.
[35] 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).

[36] 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."
[37] Official Transcript, Medicare Payment Advisory Commission, public meeting, Dec. 12, 2002.
[38] Congressional Budget Office Cost Estimate, H.R. 4600, Sept. 24, 2002.
[39] Greg Garland, "28% Rise Sought to Insure Doctors," *Baltimore Sun*, June 28, 2003.
[40] "Remarks by the President on Medical Liability Reform," University of Scranton, Scranton, Pa., Jan. 16, 2003. Transcript at: http://www.whitehouse.gov/infocus/medicalliability/
[41] Based on Public Citizen interviews with plaintiff attorneys.
[42] N. Vidmar, *Medical Malpractice and the American Jury*, 1995.
[43] According to the Physician Insurers Association of America, expert witnesses in a medical malpractice case are paid on average over $4,800.
[44] Posner et al, "Variation in Expert Opinion in Medical Malpractice Review," 85 *Anesthesiology 1049*, 1996.
[45] CBO supra note 22.
[46] United States General Accounting Office, Report GAO-03-836, "Medical Malpractice: Implications of Rising Premiums on Access to Health Care," p. 27, August 2003. Available at http://www.gao.gov/new.items/d03836.pdf.
[47] *Id*., p. 29.
[48] Chassin & Becher, "The Wrong Patient," 136 *Ann Intern Med*. 826, 2002.
[49] Agency for Health Care Administration, Risk Management Reporting Summary, March 2002.
[50] Barker et al, "Medication Errors Observed in 36 Heath Care Facilities," 162 *Arch Intern Med*. *1897*, 2002.
[51] Bates et al, "The Costs of Adverse Drug Events in Hospitalized Patients," 277 *JAMA 307*, 1997.
[52] Moss, "Spotting Breast Cancer: Doctors Are Weak Link," *New York Times*, June 27, 2002.
[53] Berens, "Infection epidemic carves deadly path," *Chicago Tribune*, July 21, 2002. This number is attributed to the "Tribune's analysis, which adopted methods commonly used by epidemiologists."
[54] *Id*.
[55] U.S. Department of Health and Human Services, "Confronting the New Health Care Crisis," July 24, 2002.
[56] J. Needleman, P. Buerhaus, S. Mattke, M. Stewart, K. Zelevinsky, "Nurse-Staffing Levels and the Quality of Care in Hospitals," *New England Journal of Medicine*, 2002; 346:1715-1722, May 30, 2002. Also: L.H. Aiken LH, S.P. Clarke, D.M. Sloane et al., "Hospital Nurse Staffing and Patient Mortality, Nurse Burnout and Job Dissatisfaction," *JAMA*, 2002;288:1987-1993, Oct. 23/30, 2002.
[57] *Id*.
[58] J. Robert Hunter, FCAS, MAAA, Director of Insurance, Consumer Federation of America, "Medical Mutual Liability Society of Maryland June 27, 2003, Rate Filing for an Increase of 28%," July 31, 2003.
[59] Notes from the Chair of the Board, newsletter of Medical Mutual Liability Insurance Society of Maryland, October 2002.
[60] Public Citizen calculation based on the five-year average (1998-2002) of dividends paid to policyholders detailed in *Best's Rating and Report Updates for Medical Mutual Liability Ins. Soc. Of Md.*, "Underwriting Experience," at www.ambest.com, June 8, 2003, p. 5.
[61] Notes from the Chair of the Board, newsletter of Medical Mutual Liability Insurance Society of Maryland, October 2002.
[62] *Best's Rating and Report Updates for Medical Mutual Liability Ins. Soc. of Md*., at www.ambest.com, June 8, 2003, p. 4.
[63] *Id.*, "Profitability Analysis," p.5.
[64] *Id.*, "Profitability Analysis," p. 4.
[65] *Id*.
[66] *Id.*, "Best's Rating," and "Rating Rationale," p.2.
[67] Notes from the Chair of the Board, newsletter of Medical Mutual Liability Insurance Society of Maryland, October 2002.
[68] "Our History: One of the Nation's Oldest, Most Trusted Carriers," at www.medicalmutualofmd.com, July 7, 2003, copyright 2002.
[69] *Best's Rating and Report Updates for Medical Mutual Liability Ins. Soc. Of Md*., at www.ambest.com, June 8, 2003, p. 4.
[70] *Id*., p. 5.
[71] "Market Share and Loss Ratio," Maryland Insurance Administration, April 2003.
[72] Public Citizen calculation based on Bureau of Labor Statistics – Medical Services CPI.

[73] "Homeowners Insurance Summary of Rate Changes, Weighted Average Change," Maryland Insurance Administration response to Public Citizen Public Information Act request, July 2003.
[74] Kaiser Family Foundation and Health Research and Educational Trust, "Employer Health Benefits, Annual Surveys, 1998-2003," Chart 6, "Average Annual Premium Costs for Covered Workers."
[75] Charles Kolodkin, "Medical Malpractice Insurance Trends? Chaos!" International Risk Management Institute. http://www.irmi.com/expert/articles/kolodkin001.asp
[76] Americans for Insurance Reform, "Medical Malpractice Insurance: Stable Losses/Unstable Rates," Oct. 10, 2002. See also: http://www.insurance-reform.org/StableLosses.pdf.
[77] "Hot Topics & Insurance Issues," Insurance Information Institute, www.iii.org
[78] Christopher Oster and Rachel Zimmerman,"Insurers' Missteps Helped Provoke Malpractice 'Crisis,'" *Wall Street Journal* , June 24, 2002.
[79] Charles Kolodkin, Gallagher Healthcare Insurance Services, "Medical Malpractice Insurance Trends? Chaos!" September 200, available at http://www.irmi.com/expert/articles/kolodkin001.asp.
[80] "State of West Virginia Medical Malpractice Report on Insurers with over 5% Market Share," Provided by the Office of the West Virginia Insurance Commission, November 2002.
[81] "Medical Malpractice Caps Fail to Prevent Premium Increases, According to Weiss Ratings Study," at www.businesswire.com, June 2, 2003.
[82] American Medical Association Report 35 of the Board of Trustees, at http://www.ama-assn.org/ama1/upload/mm/annual02/bot35a02.rtf..
[83] *Id.*
[84] Greg Garland, "28% Rise Sought to Insure Doctors," *Baltimore Sun*, June 28, 2003.
[85] Kelso & Kelso, *Jury Verdicts in Medical Malpractice Cases and the MICRA Cap*, Institute for Legislative Practice (1999). N. Vidmar, F. Gross, M. Rose, "Jury Awards for Medical Malpractice and Post-Verdict Adjustments of Those Awards," 48 *DePaul Law Review* 265, 1998. Merritt & Barry, "Is the Tort System in Crisis? New Empirical Evidence," 60 *Ohio State Law Journal* 315 (1999).
[86] *PIAA Data Sharing Report*, Report 7, Part 10.
[87] The NAIC scale grades injury severity as follows:
Emotional damage only (fright; no physical injury);
Temporary insignificant (lacerations, contusions, minor scars);
Temporary minor (infections, fall in hospital, recovery delayed);
Temporary major (burns, surgical material left, drug side-effects);
Permanent minor (loss of fingers, loss or damage to organs);
Permanent significant (deafness, loss of limb, loss of eye, kidney or lung);
Permanent major (paraplegia, blindness, loss of two limbs, brain damage);
Permanent grave (quadriplegia, severe brain damage, lifelong care or fatal prognosis);
Death
[88] N. Vidmar, F. Gross, M. Rose, "Jury Awards for Medical Malpractice and Post-Verdict Adjustments of Those Awards," 48 *DePaul Law Review* 265, 1998.
[89] "AIA Cites Fatal Flaws In Critic's Report On Tort Reform," American Insurance Association press release, March 13, 2002.
[90] "Study Finds No Link Between Tort Reforms And Insurance Rates," *Liability Week*, July 19, 1999.
[91] Michael Prince, "Tort Reforms Don't Cut Liability Rates, Study Says," *Business Insurance*, July 19, 1999
[92] Rachel Zimmerman and Christopher Oster, "Assigning Liability: Insurers' Missteps Helped Provoke Malpractice 'Crisis'; Lawsuits Alone Didn't Cause Premiums to Skyrocket; Earlier Price War a Factor," *The Wall Street Journal*, June 24, 2002.
[93] Phil Galewitz, "Underwriter Gives Doctors Dose of Reality," *The Palm Beach Post*, January 29, 2003 and Mike Salinero, "Insurers Tied To Florida Doctors," *The Tampa Tribune*, March 22, 2003.
[94] Julie Goodman, "Premiums Rise by 45 Percent; Insurance Group's Hike Comes as Doctors Seek Relief," *Clarion-Ledger* (Jackson, Miss.), September 22, 2002.
[95] Joelle Babula, "Obstetricians Say Problems Remain," *The Las Vegas Review-Journal*, October 1, 2002.
[96] "Testimony on Assembly Bill 1: To Make Various Changes Related to Medical and Dental Malpractice," Nevada Assembly Committee on Medical Malpractice Issues, July 30, 2002.
[97] "Testimony Concerning the Affordability of Medical Malpractice Insurance for Physicians Practicing in New Jersey," public hearing before the Assembly Health and Human Services Committee and Banking and Insurance Committee, June 3, 2002.

[98] James D. Hurley and Gail E. Tverberg, Tillinghast-Towers Perrin, Atlanta, "Review of Proposed Legislation," sent to Ray Cantor, director of governmental affairs, Medical Society of New Jersey, Jan. 7, 2003.
[99] "No Drop in Malpractice Rates Pending," *The Associated Press*, Jan. 10, 2003.
[100] *Id.*
[101] Testimony at the Wyoming Legislature's Joint Labor, Health and Social Services Interim Committee, Dec. 4-6, 2002.
[102] See http://www.citizen.org/publications/release.cfm?ID=7168
[103] See www.questionabledoctors.org
[104] J.D. Birkmeyer, C.M. Birkmeyer, D.E. Wennberg, M.P. Young, "Leapfrog Safety Standards: Potential Benefits of Universal Adoption." The Leapfrog Group. Washington, DC, 2000. Available at: http://www.leapfroggroup.org/PressEvent/Birkmeyer_ExecSum.PDF.
[105] D.W. Bates, L.L. Leape, D.J. Cullen, N. Laird , et al. "Effect of Computerized Physician Order Entry and a Team Intervention on Prevention of Serious Medical Errors," *Journal of the American Medical Association*, 1998; 280:1311-6.
[106] Sandra G. Boodman, "No End to Errors," *Washington Post*, Dec. 3, 2002.
[107] J.D. Birkmeyer, "High-Risk Surgery – Follow the Crowd," *Journal of the American Medical Association*,. 2000; 283:1191-3; See also R.A. Dudley, K.L. Johansen, R. Brand, D.J. Rennie, A. Milstein, "Selective Referral to High Volume Hospitals: Estimating Potentially Avoidable Deaths," *Journal of the American Medical Association*, 2000; 283: 1159-66.
[108] "A Follow-Up Review of Wrong Site Surgery," Joint Commission on Accreditation of Healthcare Organizations, *Sentinel Event Alert*, Issue 24, Dec. 5, 2001.
[109] "Joint Commission Issues Alert: Simple Steps By Patients, Health Care Practitioners Can Prevent Surgical Mistakes." See Joint Commission on Accreditation of Healthcare Organizations website: http://www.jcaho.org/news+room/press+kits/joint+commission+issues+alert+simple+steps+by+patients,++health+care+practitioners+can+prevent+surg.htm
[110] Florida Agency for Health Care Administration, Risk Management Reporting Summary, 24 Hour Reports and Code 15 Reports, 2001, March 2002.
[111] American Medical Student Association, "Fact Sheet, Support H.R. 3236 Limiting Resident-Physician Work Hours;" See also: http://www.amsa.org/hp/rwhfact.cfm.
[112] *Id.*
[113] *Id.*
[114] *Id.*
[115] Public Citizen, "Petition to the Occupational Safety and Health Administration requesting that limits be placed on hours worked by medical residents (HRG Publication #1570)," April 30, 2001; See also: http://www.citizen.org/publications/release.cfm?ID=6771.
[116] J. Robert Hunter, "Action Required by Insurance Commissioners to Regulate Insurance Industry," Americans for Insurance Reform, July 30, 2002.