ALASKA LEGISLATURE COMMITTEE FILES, 2003-2004 8672
11253 SENATE LABOR & COMMERCE

If an entity that is required to report to the data bank fails to report, it is subject to a civil penalty of not more than $10,000 for each payment not reported.[1390]

Section 627.062, Florida Statutes, provides the requirements to be met by medical malpractice insurance companies in establishing rates and to be used by the Department of Insurance in reviewing the rates filed. The rates filed are not to be excessive, inadequate, or unfairly discriminatory.[1391] The Department is required to review all rate filings to determine if the rate is excessive, inadequate, or unfairly discriminatory.[1392] In making that determination, the statute requires the Department to consider a series of criteria, including the past and prospective loss experience within and without Florida.[1393] The statute does not provide guidance regarding what losses should be included in determining the loss experience. Further, there is no provision in the statute prohibiting insurance companies providing medical malpractice insurance from considering bad faith awards or punitive damage awards in determining rates.

Section 627.651, Florida Statutes, provides for the calculation of rates for automobile insurance. Subsection (12) of that section prohibits motor vehicle insurers from including any portion of a judgment or settlement resulting from a bad faith action or punitive damages award or settlement against the insurer in the insurers rate base or to justify a rate or a rate change. Further, the insurer may not include any attorney fees or costs related to defending a bad faith or punitive damages claim in establishing rates or justifying a rate change.

Information Presented to the Task Force

According to Mr. Steve Roddenberry,[1394] the Department of Insurance does not warrant the accuracy of the data contained in the closed claim database. The database was established only to allow consumers to look up whether a doctor had a claim filed against him or her.[1395] It was never intended to be a "barometer of the medical malpractice insurance market."[1396]

[1390] Id.
[1391] Section 627.062(1), Florida Statutes.
[1392] Section 627.62(2)(b), Florida Statutes.
[1393] Section 627.062(2)(b)1, Florida Statutes.
[1394] Steve Roddenberry, Deputy Director of the Division of Insurer Services at the Florida Department of Insurance.
[1395] Steve Roddenberry, testimony, Nov. 4, 2002, pg. 398.
[1396] Id. at 399.

Mr. Roddenberry also discussed the issue of whether punitive damages and bad faith claims should be included in the determination of rates. He stated that while Florida law does not specifically prohibit the inclusion of those losses in rate determinations for medical malpractice insurance policies, the Department of Insurance tries to exclude those losses now.[1397] He testified the Department does all it can "to ensure that bad faith losses are either immaterial or backed out of claim losses prior to considering a rate increase."[1398]

Findings and Recommendations

The Task Force finds that section 627.912, Florida Statutes, does not require the covered insurers to provide information related to the amount paid in settlement or verdict for the categories of damages, the amount claimants actually received in settlements or verdicts reduced after a trial, or how much insurers pay in cases involving multiple defendants. Further, the information collected by the Department of Health pursuant to section 456.049, Florida Statutes, is not forwarded to the Department of Insurance for inclusion in the closed claims database. The information reported to the National Practitioner Data Bank is more comprehensive than the information reported to the Florida Department of Insurance. Further, the Task Force finds there is nothing in law that prohibits a medical malpractice insurer from including judgments or settlements of punitive damages or bad faith claims in establishing insurance rates or in the justification of a rate change.

Recommendation 1. The Legislature should authorize the Department of Insurance to require insurers to provide additional information on closed claims and to penalize the insurers for failure to provide the required data.

Recommendation 2. The Department of Health should forward the information collected pursuant to section 456.049, Florida Statutes, to the Department of Insurance

Recommendation 3. The Legislature should require every entity reporting to the National Practitioner Data Bank to report the same information to the Department of Insurance for inclusion in the closed claim data files.

[1397] Steve Roddenberry, testimony, Jan. 16, 2003, pg. 47.
[1398] Id. at 48.

Recommendation 4. The Legislature should require the Department of Insurance to compile and review the collected data and fine those entities failing to fully comply with the requirements of law.

Recommendation 5. The Legislature should include in section 627.062, Florida Statutes, related to the setting of rates for most insurers, the provisions of section 627.0651(12), Florida Statutes, prohibiting the inclusion of payments made by insurers for bad faith or punitive damages claims.

Chapter 11 - Conclusion

> *"Our Harvard medical practice study found both the medical and legal systems in urgent need of change. We discovered that in New York's hospitals more than 100,000 patients were injured annually because of medical management practices, more than one-quarter from negligence. (More recently we have found a similar picture in Utah and Colorado.) Fewer than 7 percent of New York's injured patients received compensation through the courts, however, of those, fewer than 20 percent were injured because of negligence. So the legal system is even more prone to error than the medical system it attempts to judge."*
>
> Howard Hiatt & Paul Weiler, No Fault Medical Coverage Would Cure Many Ills, The Boston Globe A27 (Nov. 5, 1999)

This Task Force has received extensive testimony and written information related to the current healthcare provider liability insurance crisis. Information was presented to the Task Force on the extent of the crisis, the impact of the crisis on the provision of healthcare in Florida and the nation, and the causes of the crisis. The suggested causes included the medical malpractice insurance underwriting cycle, insurance company investment losses, and the significant increases in medical malpractice insurance company claims losses resulting from the increased frequency and severity of claims. Based on the Task Force's analysis of the information presented, the Task Force set out findings in chapter 5 of this report related to the extent and causes of the crisis.

The Task Force also received extensive testimony and documentation related to proposed solutions to the healthcare provider liability insurance crisis. The Task Force examined an extensive list of proposals from various persons or entities meant to address the crisis in whole or in part. Chapters 6 through 10 of this report examine the law and related testimony as well as documentary information received by the Task Force regarding those proposed legislative changes the Task Force determined would have some impact in addressing this crisis and in minimizing or removing the possibility this problem will arise again in the future.

In chapters 6 through 10, the Task Force proposes a comprehensive package of reforms including changes to improve the quality of care provided in our medical institutions, improved healthcare provider discipline, tort reforms, reforms to the alternative dispute resolution process, and insurance reforms. The Task Force is of the opinion that,

while these comprehensive reforms are important, the centerpiece and the recommendation that will have the greatest long-term impact on healthcare provider liability insurance rates, and thus on the availability and affordability of healthcare in Florida, is a $250,000 cap on non-economic damages.

In summary, the last few years have resulted in a marked decrease in profitability for professional healthcare liability insurance in the State of Florida. With an industry combined ratio of 184.2 percent, the viability of this market may be threatened if conditions continue to deteriorate.

The recommendations are listed below and are also listed, along with the discussions regarding each proposed recommendation, in chapters 6 through 10 of this report.

Recommendations

Healthcare Quality

Recommendation 1. The Legislature should establish a Patient Safety Authority, or an entity similar in concept, as both a short-term and long-term strategy to improve patient safety. There are two options that should be considered. The first option, which is recommended by the Institute of Medicine, is to have two systems, one for the mandatory reporting of adverse events and another for the voluntary reporting of near misses. The second option is to have a single entity, similar to the Patient Safety Authority in Pennsylvania, that would analyze all adverse events and near misses. Experts would analyze these data and make recommendations to facilities about how to reduce these events and near misses. Information would not be subject to discovery in lawsuits.

Recommendation 2. The Legislature should timely develop or adopt a statewide electronic medical record and physician medication ordering system. The system should be developed in partnership with hospitals, physicians, and other healthcare providers. The physician medication ordering system should be implemented first. The system could then be implemented in stages with a possible approach of beginning with a web-based data exchange platform that establishes interconnectivity between providers. Another possibility is to begin with business functions, which provide an early return on investment, and then include clinical functions.

Recommendation 3. The Legislature should consider creating a statutory public-private non-profit entity that would administer the Patient Safety Authority, statewide electronic medical record, and build an information technology infrastructure to support the delivery of healthcare that would include a statewide physician medication ordering system. Funding could

possibly come from a $1 per year surcharge on all health professional licenses; all hospital, ambulatory care surgery center, nursing home, home health agency, and birth center discharges; and all individuals in managed care plans and insurance plans licensed under chapters 627 and 640, Florida Statutes. Health providers, insurers, businesses, and government would be represented on the governing board of directors. Options for implementation include:

- Affiliating with a university for the analysis of voluntarily-reported adverse events and "near misses."
- Contracting with an information technology firm(s) for a statewide physician medication ordering system, web-based platform for health provider interconnectivity, and electronic patient record.
- Developing a business plan and future financing strategy to supplement the $1 annual surcharge, which will likely be necessary to achieve full implementation.
- Including in the business plan a strategy to begin with computerizing business functions, for providers to quickly achieve cost-savings due to automation efficiencies, and then include clinical functions.

Recommendation 4. The Legislature should be encouraged to authorize the two "no fault" medical malpractice demonstration projects recommended in the IOM November 2002 report, Fostering Rapid Advances in Healthcare, at a university healthcare system or statutory teaching hospital. This project would be governed by criteria compatible with that proposed by the IOM.

Recommendation 5. If Recommendation 4 is implemented, contingency fees for attorneys should be eliminated from the claims bill process in the no-fault demonstration project.

Recommendation 6. The Legislature should require each hospital and ambulatory surgery center to have a patient safety plan, a patient safety committee, and a patient safety officer. Members of the public should have representation on patient safety committees.

Recommendation 7. The Legislature should require healthcare providers to notify patients who experience serious medical injuries to be notified of the injury in person.

Recommendation 8. The Legislature should examine the feasibility of using Medicaid funding to create a pilot project for an electronic medical record and a physician medication ordering system for Medicaid patients.

Recommendation 9. The Legislature should examine the feasibility of developing a process in the Insurance Code for hospitals and other healthcare facilities to receive malpractice insurance discounts if they implement certified patient safety programs.

Recommendation 10. The Legislature should establish a high-technology simulation center for use by all health providers. Florida should encourage use of this center by practitioners in other states to help offset the costs for the center.

Recommendation 11. The Legislature should require all medical schools, nursing schools, and allied health schools to include in their curricula courses on patient safety and patient safety improvement.

Recommendation 12. The Legislature should require the Agency for Health Care Administration (AHCA) to conduct a study to determine if it is feasible to provide information to the public to help them make better healthcare decisions regarding the choice of a hospital. The information would not be presented in a "report card" format. AHCA should be provided with sufficient resources to conduct the study in cooperation with hospitals, physicians, and other healthcare providers and provide the Governor and Legislature with a report.

Physician Discipline

Recommendation 13. The Legislature should allow the healthcare provider regulatory boards to appoint administrative law judges with expertise in the profession to hear standard of care cases.

Recommendation 14. The Legislature should statutorily provide that standard of care decisions are, as a matter of law, infused with overriding policy considerations best left to the healthcare provider regulatory boards.

Recommendation 15. The Legislature should authorize the healthcare provider regulatory boards to reassess and resolve conflicting evidence in standard of care cases based on the record in the case.

Recommendation 16. The Legislature should require physician profiles to provide professional qualifications information regarding physicians to consumers.

Recommendation 17. The Legislature should provide for an audit of the Department of Health's disciplinary process and closed claims files.

Recommendation 18. The Florida Legislature should strengthen Florida's peer review requirements so they can lead to earlier dismissal of meritless claims brought against hospitals by aggrieved physicians and protect physicians and hospitals from costly lawsuits and liability.

Recommendation 19. The Legislature should expand the DOH's subpoena authority to include the retrieval of patient records when the patient refuses to cooperate, is unavailable, or fails to execute a patient release. Records obtained under these circumstances would be confidential.

Recommendation 20. The Legislature should require that all first offense citations be non-disciplinary and non-reportable to the national data banks.

Recommendation 21. The Legislature should expand the timeframe for forwarding cases to the Division of Administrative Hearing from fifteen days to forty-five days when a demand for a formal hearing, pursuant to section 120.57(1), Florida Statutes, is received.

Recommendation 22. The Legislature should require all healthcare provider regulatory boards to designate those violations that may be handled in a one-time, non-reportable, and confidential mediation proceeding. Appropriate standard of care cases shall be included.

Recommendation 23. The Legislature should modify upward the dollar amount threshold for closed claims cases to be reported and investigated by the Department.

Recommendation 24. The Legislature should grant exclusive authority to the healthcare provider regulatory boards to determine the amount of administrative costs to be recovered when final action occurs and a respondent is disciplined.

Recommendation 25. The Legislature should change the burden of proof in disciplinary actions from the "clear and convincing evidence" standard, to the "greater weight of the evidence" standard, which is the same burden of proof for a medical malpractice case.

Recommendation 26. The Legislature should expand the healthcare provider regulatory board's rulemaking authority in the areas of Internet prescribing and sexual misconduct cases so as to better address critical areas of discipline.

Tort Reform

Cap on Non-Economic Damages

Recommendation 27. The Legislature should, in medical malpractice cases, cap non-economic damages at $250,000 per incident. The Task Force believes that a cap on non-economic damages will bring relief to this current crisis. Without the inclusion of a cap on potential awards of non-economic damages in a legislative package, no legislative reform plan can be successful in achieving the goal of controlling increases in healthcare costs, and thereby promoting improved access to healthcare. Although the Task Force was offered other solutions, there is no other alternative remedy that will immediately alleviate Florida's crisis of availability and affordability of healthcare. The evidence before the Task Force indicates that a cap of $250,000 per incident will lead to significantly lower malpractice premiums.

The Legislature should commission and fund a study of the impact of the $250,000 cap on non-economic damages. An interim report should be submitted to the Legislature five years after date of enactment.

Communications with Subsequent Treating Physicians

Recommendation 28. The Legislature should amend the Florida Statutes to allow *ex parte* communication between defense counsel for a defendant in a medical malpractice lawsuit and the plaintiff's treating physicians.

Recommendation 29. As an alternative, the Legislature may consider requiring the plaintiff to execute a medical information release when filing a lawsuit that would allow for the defendant to conduct *ex parte* interviews with the plaintiff's treating physicians only in areas potentially relevant to the plaintiff's alleged injury or illness.

Expert Witness Qualifications

Recommendation 30. The Legislature should examine ways to improve the use of in-kind experts at trial.

Limitation on Liability Related to Emergency Services

Recommendation 31. The Legislature should retain the definition of "reckless disregard," as that term is currently defined by statute, as it is sufficient.

Recommendation 32. The Legislature should repeal references to patient stabilization in section 768.13(2)(b)2a, Florida Statutes.

Sovereign Immunity

Recommendation 33. The Legislature should amend section 768.28, Florida Statutes, to define healthcare professionals providing services in emergency rooms or trauma centers as agents of the state for purposes of sovereign immunity.

Periodic Payment of Damages

Recommendation 34. The Legislature should amend the Florida Statutes to allow the periodic payment of future non-economic damages.

Recommendation 35. The Legislature should amend the Florida Statutes to terminate the payment of future economic and non-economic damages on the death of the plaintiff.

Pre-Suit Reform

Recommendation 36. The Legislature should require experts reviewing pre-suit claims and defenses and rendering opinions be qualified, in that they possess similar if not identical credentials and expertise in the field of healthcare services of the defendant's particular specialty.

Recommendation 37. The Legislature should require the expert who reviews pre-suit claims and defenses and renders opinions be subject to discovery and his or her testimony be admissible in any future proceeding.

Joint and Several Liability

Recommendation 38. Joint liability has a negative impact on a medical malpractice insurer's ability to forecast future losses and contributes to the insurer's paid losses. Accordingly, the Legislature should amend section 768.81, Florida Statutes, to provide that a defendant's liability for both economic and non-economic damages be several only.

Set Off of Settlement Proceeds

Recommendation 39. The Legislature should amend the set off statutes, sections 46.015 and 768.041, Florida Statutes, to clarify that set off amounts should be applied to jury damage awards, including both economic and non-economic damages, even when fault is several only.

Alternative Dispute Resolution

Mandatory Mediation

Recommendation 40. The Legislature should encourage pre-suit mediation by providing for confidentiality of any pre-suit mediation in a medical malpractice case in the same manner as is provided for mediation occurring after suit is filed.

Recommendation 41. The Legislature should amend the mandatory mediation provisions of section 766.108, Florida Statutes, to require mediation within 120 days of filing suit and to provide sanctions if a good-faith offer of settlement is refused.

Recommendation 42. The Legislature should not make admissible at trial the fact that mandatory mediation occurred or that offers of settlement were made, but should make this fact admissible for purposes of enforcing the attorney fees and costs. The mediator should maintain a report of the issues and facts presented at the mediation and the final settlement offers of each party at the mandatory mediation.

Recommendation 43. The Legislature should enact specific criteria similar to those in the offer of judgment statute to be considered by the court in making the determination as to how close in amount to the offer the judgment must be and the criteria to be used in evaluating the amount of the attorney fees and costs to be awarded in addition to the standards generally considered in awarding fees and costs.

Recommendation 44. The Legislature should require the court to consider, in addition to all other criteria, whether the issues and facts presented at mediation were significantly the same issues presented at trial.

Voluntary Binding Arbitration

Recommendation 45. The Legislature should amend the definitions of "economic damages" and "non-economic damages" as provided in sections 766.202 and 766.207, Florida Statutes, to provide that such damages are recoverable in voluntary binding arbitration only if the claimant has the right to recover such damages under general law, including the Wrongful Death Act.

Recommendation 46. The Legislature should provide for an aggregate cap on non-economic damages in arbitrated cases of multiple defendants.

Insurance Reform

NICA

Recommendation 47. The Legislature should maintain the NICA program because of its success and should further consider and study the issues for broadening the NICA program, as discussed in this report.

Bad Faith

Recommendation 48. The Legislature should restore the insured as the owner of the bad faith cause of action. The common law cause of action, as outlined by the Supreme Court in 1980 should be legislatively cured so that the Florida Legislature preempts that rule and only insureds, not third party plaintiffs, can bring a bad faith cause of action against its insurer. In addition, section 624.155, Florida Statutes, should be amended to also limit the proper party in a bad faith cause of action to the insured only.

Recommendation 49. The Legislature should articulate standards of what constitutes bad faith on the part of an insurer.

Recommendation 50. The Legislature should require that the maximum liability for bad faith be calculated as the amount of damages that were

actually caused by the acts of bad faith, limited by the amount of the reachable assets of the insured.

Recommendation 51. The Legislature should require that, if an insurer is found to be in bad faith or settles a case for bad faith, the Department of Insurance is to be notified of such finding.

Recommendation 52. The Department of Insurance should conduct an investigation into the specific allegations of the insurer and into the insurer's general practices and should take necessary action against the insurer to punish and prevent future bad faith practices.

Alternative Insurance Products

Recommendation 53. The Legislature should repeal the prohibition against creating Medical Malpractice Risk Management Trust Funds in section 627.357, Florida Statutes.

Recommendation 54. The Legislature should encourage the creation of self-insured options for healthcare providers.

Recommendation 55. The Legislature should expand the rulemaking authority of the Department of Insurance for self-insurance programs to ensure they remain solvent and provide the insurance coverage purchased by participants.

Insurance Company Regulation

Recommendation 56. The Legislature should authorize the Department of Insurance to require insurers to provide additional information on closed claims and to penalize the insurers for failure to provide the required data.

Recommendation 57. The Department of Health should forward the information collected pursuant to section 456.049, Florida Statutes, to the Department of Insurance.

Recommendation 58. The Legislature should require every entity reporting to the National Practitioner Data Bank to report the same information to the Department of Insurance for inclusion in the closed claim data files.

Recommendation 59. The Legislature should require the Department of Insurance to compile and review the collected data and fine those entities failing to fully comply with the requirements of law.

Recommendation 60. The Legislature should include in section 627.062, Florida Statutes, related to the setting of rates for most insurers, the provisions of section 627.0651(12), Florida Statutes, prohibiting the inclusion of payments made by insurers for bad faith or punitive damages claims.

SB

319

(FILE 5 OF 5)

SENATE COMMITTEE REPORT
First Committee of Referral

DATE: 2/11/04

FURTHER: Judiciary

Date of 5-Day Notice: _____
(in accordance with Uniform Rule 23)

DATE TURNED
IN TO OFFICE: _____

Labor and Commerce Committee considered SENATE BILL NO. 319

SB 319 CLAIMS AGAINST HEALTH CARE PROVIDERS

"An Act relating to claims for personal injury or wrongful death against health care providers; and providing for an effective date."

and recommends:

[ ] be **replaced** with _____ **CS** _____ (_____)

[ ] adopt **previous** _____ **CS** _____ (_____)

[ ] attached amendment(s)

[ ] adopt Letter of Intent by _____ Committee

[ ] further referral to _____ Committee

Senate Bill:
[ ] Same Title
[ ] New Title

House Bill:
[ ] Same Title
[ ] Technical Title Change
[ ] New Title w/ SCR #_____

NEW FISCAL NOTE(S):

Department	Date	Fiscal	Indet.	Zero	FN#

PREVIOUS FISCAL NOTE(S):

Department	Date	Fiscal	Indet.	Zero	FN#

[ ] **APPROPRIATION - no fiscal note**

SIGNATURES AND RECOMMENDATIONS:	DO PASS	DO NOT PASS	NO REC	AMEND
		X		
		X		
			✓	
			X	
CHAIR: C Bentley			✓	

2002 ALASKA PROPERTY AND CASUALTY MARKET SHARE

11 - MEDICAL MALPRACTICE ($000)

COMPANY NAME	PERCENT OF MARKET	DIRECT PREMIUMS WRITTEN
Medical Ins Exch of CA	34.92	4,411
Norcal Mut Ins Co	34.43	4,349
Continental Cas Co	10.34	1,306
Northwest Physicians Mut Ins Co	5.00	631
National Surety Corp	2.95	373
Doctors Co An Interins Exchn	2.09	264
American Cas Co of Reading PA	1.68	212
Physicians Ins A Mut Co	1.66	210
NCMIC Ins Co	1.54	195
Chicago Ins Co	1.23	155
Firemans Fund Ins Co	1.09	137
TIG Ins Co	1.04	132
Medical Protective Co	0.84	106
Granite State Ins Co	0.30	38
St Paul Fire & Marine Ins Co	0.24	30
Gulf Ins Co	0.21	26
National Union Fire Ins Co of Pitts	0.12	15
Ace American Ins Co	0.10	12
Westport Ins Corp	0.09	11
American Alt Ins Corp	0.07	9
TOTAL FOR TOP 20 RANKED INSURERS	**99.91**	**12,622**
TOTAL FOR ALL 39 INSURERS WRITING THIS LINE	**100.00**	**12,633**

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2002 ALASKA PROPERTY AND CASUALTY BUSINESS

11 - MEDICAL MALPRACTICE ($000)

COMPANY NAME	DOM	DIRECT PREMIUMS WRITTEN	DIRECT PREMIUMS EARNED	DIVIDENDS PAID	DIRECT LOSSES PAID	DIRECT LOSSES INCURRED
Ace American Ins Co	PA	12	25	0	0	-2
Ace Fire Underwriters Ins Co	PA	0	0	0	0	1
American Alt Ins Corp	DE	9	7	0	0	-1
American Cas Co of Reading PA	PA	212	202	0	0	25
American Ins Co	NE	5	1	0	0	0
Century Ind Co	PA	0	0	0	0	0
Chicago Ins Co	IL	155	159	0	242	77
Church Mut Ins Co	WI	0	0	0	0	0
Cincinnati Ins Co	OH	1	0	0	0	1
Continental Cas Co	IL	1,306	1,120	0	2,054	2,067
Doctors Co An Interins Exchn	CA	264	189	0	45	193
Fairmont Ins Co	CA	1	1	0	0	1
Federal Ins Co	IN	0	0	0	0	0
Firemans Fund Ins Co	CA	137	98	0	1	27
Granite State Ins Co	PA	38	29	0	0	18
Gulf Ins Co	CT	26	24	0	0	-21
Illinois Natl Ins Co	IL	0	0	0	0	-9
Insurance Co of North Amer	PA	0	0	0	0	-1
Medical Ins Exch of CA	CA	4,411	4,238	958	845	2,085
Medical Protective Co	IN	106	193	0	0	-179
National Fire Ins Co of Hartford	CT	0	2	0	0	25
National Surety Corp	IL	373	383	0	26	110
National Union Fire Ins Co of Pitts	PA	15	2	0	1,079	481
NCMIC Ins Co	IA	195	185	29	1	161
Norcal Mut Ins Co	CA	4,349	4,299	0	1,595	1,509
Northwest Physicians Mut Ins Co	OR	631	550	0	1,150	1,891
OHIC Ins Co	OH	5	39	0	0	-1,146
Pacific Employers Ins Co	PA	0	0	0	0	0
Physicians Ins A Mut Co	WA	210	208	0	0	100
St Paul Fire & Marine Ins Co	MN	30	34	0	-500	-915
St Paul Medical Liability Ins Co	MN	0	0	0	0	-12
St Paul Mercury Ins Co	MN	0	0	0	0	0
TIG Ins Co	CA	132	119	0	0	90
Travelers Cas & Surety Co	CT	0	0	0	0	-21
Travelers Ind Co of IL	IL	0	0	0	0	4
United States Fire Ins Co	NY	0	0	0	0	-1
US Fidelity & Guaranty Co	MD	0	0	0	0	0
Vigilant Ins Co	NY	0	0	0	0	0
Westport Ins Corp	MO	11	11	0	0	3
Totals		**12,633**	**12,119**	**987**	**6,537**	**6,564**
39 Companies						

RECAP OF 2002
SURPLUS LINES PREMIUMS
($000)

FIRE	14,011
ALLIED	2,883
HOME OWNERS MULTI PERIL	235
COMMERCIAL MULTI PERIL	3,659
OCEAN MARINE	337
MEDICAL MALPRACTICE	306
EARTHQUAKE	2,964
EXCESS WORKERS' COMPENSATION	27
LIQUOR LIABILITY	233
DAYCARE LIABILITY	139
POLLUTION LIABILITY	4,651
LEGAL PROFESSIONAL LIABILITY	3,106
ARCHITECTS PROFESSIONAL LIABILITY	1,273
OTHER PROFESSIONAL LIABILITY	2,931
OTHER LIABILITY	19,574
COMMERCIAL AUTO LIABILITY	388
PRIVATE PASSENGER AUTO PHYSICAL DAMAGE	110
COMMERCIAL AUTO PHYSICAL DAMAGE	373
COMMERCIAL AIRCRAFT	11,244
PERSONAL AIRCRAFT	-94
FIDELITY	12
ALL OTHER	4,151
TOTAL	**72,513**

NAIC COCODE	COMPANY NAME	ASSETS	SURPLUS
20478	National Fire Ins Co of Hartford	217,174	143,004
42447	National General Assur Co	34,678	8,518
23728	National General Ins Co	144,609	30,573
20087	National Ind Co	36,192,654	15,732,073
32620	National Interstate Ins Co	159,905	36,747
20052	National Liab & Fire Ins Co	409,541	167,237
34835	National Reins Corp	1,134,824	655,756
19364	National Std Ins Co	11,894	11,673
21881	National Surety Corp	399,025	99,295
19445	National Union Fire Ins Co of	16,458,602	5,885,057
26093	Nationwide Affinity Co of Amer	12,178	12,161
10723	Nationwide Assur Co	65,837	60,967
23760	Nationwide General Ins Co	19,862	19,646
25453	Nationwide Ins Co of Amer	66,762	60,237
23779	Nationwide Mut Fire Ins Co	3,372,949	1,126,376
23787	Nationwide Mut Ins Co	19,673,534	5,605,742
37877	Nationwide Prop & Cas Ins Co	23,730	23,512
42307	Navigators Ins Co	438,842	128,543
15865	NCMIC Ins Co	371,967	133,145
21830	New England Ins Co	238,042	234,703
23833	New Hampshire Ind Co Inc	312,113	79,907
23841	New Hampshire Ins Co	2,044,793	596,938
12130	New South Ins Co	75,829	28,395
16608	New York Marine & Gnrl Ins Co	447,462	165,961
24643	Newark Ins Co	105,013	5,659
10967	Newport Mut Ins RRG Inc	3,840	929
35106	Niagara Fire Ins Co	120,557	71,792
32301	Nichido Fire & Marine Ins Co Ltd	87,052	40,357
27073	Nipponkoa Ins Co Ltd U.S.	154,894	51,214
33200	Norcal Mut Ins Co	786,918	222,214
29874	North American Specialty Ins Co	318,478	168,558
21105	North River Ins Co	670,277	229,022
22047	North Star Rein Corp	25,222	15,607
36455	Northbrook Ind Co	89,395	89,018
19224	Northbrook Prop & Cas Ins Co	349,316	220,324
38369	Northern Assur Co of Amer	437,383	139,120
19372	Northern Ins Co of NY	25,809	25,809
24031	Northland Cas Co	97,448	22,482
43583	Northwest Physicians Mut Ins	62,452	7,255
23914	Northwestern Ntl Ins Co	80,004	5,741
23248	Occidental Fire & Cas Co of NC	139,896	63,612
23680	Odyssey America Reins Co	3,205,981	990,469
25070	Odyssey Reins Corp	1,047,101	487,116
35602	OHIC Ins Co	270,505	60,921
24074	Ohio Cas Ins Co	2,141,161	725,748
24082	Ohio Security Ins Co	62,347	34,164
24147	Old Republic Ins Co	1,589,636	536,439
35424	Old Republic Minnehoma Ins Co	75,606	13,863
37060	Old United Cas Co	186,646	31,536
12254	Omaha Ind Co	26,306	18,060

Norcal Mut Ins Co

NAIC#: 33200 **Home Office:** California

Business Type: Property/Casualty

Other Reports: Financial Information Writing Insurance Complaints

Below is the Financial Profile Report for Norcal Mut Ins Co for the year ending Decembe 2002. For a glossary of terms used in this report please refer to the CIS Profile Help. may also obtain this report in Adobe Acrobat PDF format. (A free version of Adobe Acroba Reader is available at adobe.com.)

Get Profile a

NORCAL MUT INS CO PROFILE FOR 2002

NAIC Company Code: 33200

Group Code: 1282

State of Domicile: California

Group Name: MEDICAL G HOLDINGS AFFILIATES

Business Type: Property/Casualty

FEIN: 94-230105

Assets: $786,918,341

Direct Premiums Written: $181,511,2

Liabilites: $564,704,499

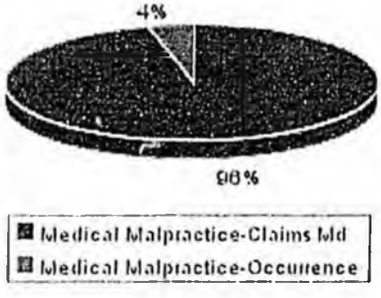
Capital and Surplus: $222,213,8

Assets to Liability Ratio: 1.39 to 1

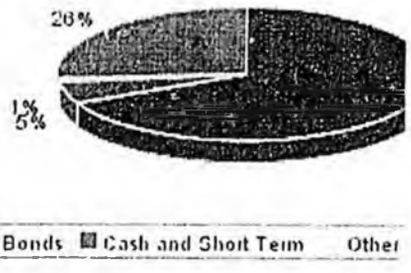
Policyholder Contact: Address: 560 Davis Street, Second Floor, San Francisco, CA 9411

Telephone: 800-652-1051 Web: http://www.norcalmutual.com

Premiums Written By Line of Business

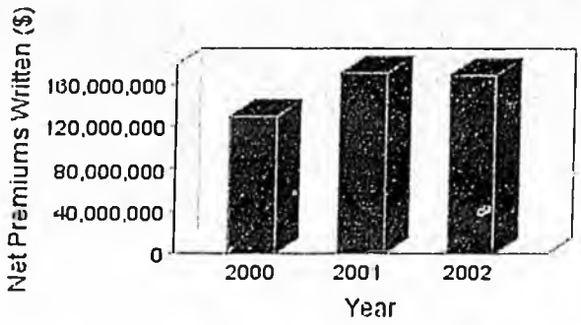


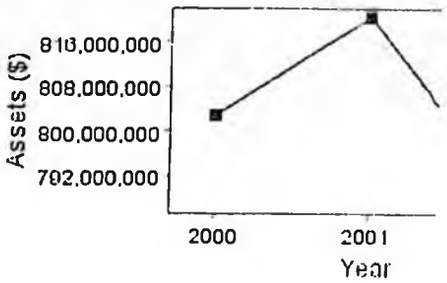
Invested Asset Mix for 200



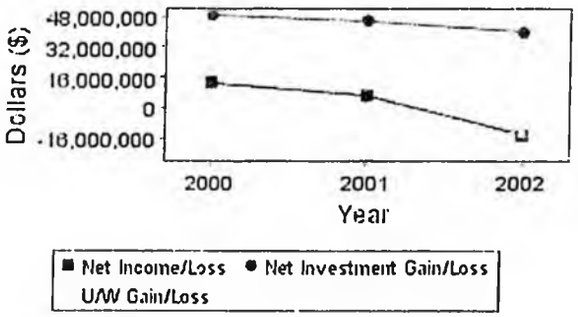
Three Year Net Premiums Written

Three Year Asset Trend





Three Year Net Income/Loss Trend



Profile Report Source: NAIC Financial Data Repository

Report Date: 3/11/2004

THE ALASKA ACTION TRUST
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POSITION PAPER ON HOUSE BILL 472/SENATE BILL 319
Alaska Action Trust

INTRODUCTION

In Alaska, to suggest that there is a medical malpractice crisis is at best disingenuous and at worse fraudulent. In short, there is no empirical evidence to support the proposition of a relationship between medical malpractice premiums, medical malpractice litigation and availability of health care providers.

If this proposed legislation passes, you will be responsible for eliminating the ability of stay at home moms and dads, retired or elderly citizens, children, and those with subsistence lifestyles or limited incomes to bring claims against negligent or even reckless doctors or other health care providers. This will be true even when they are blinded, maimed, suffer serious neurological injuries, rendered sexually dysfunctional or even killed by medical malpractice. What makes this proposed legislation even more egregious is that the entire premise for its utility is based upon anecdotal information, unsupported by credible empirical evidence and indeed is contrary to conclusions reached in existing and reliable studies.[1] Even more appalling, there is no corresponding assurance from those most benefited (the insurance industry) that the legislation will have *any* effect whatsoever on medical malpractice rates.

THE HISTORY OF TORT REFORM IN ALASKA

While the following discussion will illustrate the points referenced above, a brief chronological history of similar tort reform efforts in the State of Alaska demonstrates that capping or limiting damages will have absolutely no effect on medical malpractice insurance rates or the availability of medical malpractice insurance to doctors in Alaska or the availability of health care in Alaska.

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[1] Studies repeatedly relied upon by the insurance industry and health care providers pushing similar legislation have been widely discredited. The Milliman report, for instance, relies on data from the National Practitioner Data Bank (NPDP) that has been slammed by the Government Accounting Office (GAO). (*See, e.g.*, GAO: "National Practitioner Data Bank: Major Improvements are Needed to Enhance Data Bank's Reliability," Nov. 2000; Mary Jane Fisher, "GAO Report Slams National Practitioner Data Bank," *National Underwriter*, Jan. 1, 2001). It also fails to adjust any of its figures for medical inflation to offset its conclusion that medical malpractice losses have risen 32% over the last decade in states without caps. When adjusted for 51% in medical inflation for the same time period, paid losses are actually *falling*.

Dating back to 1976 with the passage of A.S. 09.55.548, medical malpractice insurers and health care providers have enjoyed a unique benefit unavailable to other insurers or private citizens. A.S. 09.55.548(b) in effect immunizes these entities and individuals from payment for all past medical expenses incurred as a result of physician and/or health care malpractice paid by private health care plans.

This has resulted in a significant windfall to medical malpractice carriers (and uninsured health care providers) since a private health care plan has no subrogation rights under the statute. The only exception to this windfall is when the collateral source of payment is governmental or quasi governmental such as under Medicare, Medicaid or federal employees who are insured under the federal health care plan. In many cases, this results in savings totaling hundreds of thousands of dollars which are absorbed, unfairly, by other health care plans and ultimately by the citizens of this state through higher health care premiums.

In 1978, again at the urging of medical malpractice insurance carriers and health care providers, the Legislature passed A.S. 09.55.536 requiring the appointment of expert advisory panels in all medical malpractice actions. These panels were appointed by the court and reviewed claims brought by injured Alaskans to determine whether or not malpractice had occurred and, if so, whether the malpractice had caused the patient's injuries. The purported basis for this legislation (as argued by its proponents) was to eliminate or at least minimize frivolous malpractice claims. While the efficacy of the expert advisory panel was always questionable, it has been all but abandoned by health care providers themselves and is no longer requested (it is waived in virtually all cases).

In 1986, the Legislature enacted tort reform legislation placing damage caps on non-economic damage. That legislation capped non-economic damages for injuries that did not result in severe permanent physical impairment or severe disfigurement to $500,000. There was no cap, however, on those injuries that did result in severe permanent impairment or severe disfigurement.

In 1997, sweeping tort law revision was enacted by the Legislature. The previous cap on non-economic damages in cases involving physical injury was reduced to $400,000 (or the injured person's life expectancy multiplied by $8,000) A definitive cap was placed on cases involving severe permanent physical impairment and severe disfigurement of $1,000,000 or the injured persons life expectancy in years multiplied by $25,000. In other words, to exceed the $1,000,000 limitation, a person's life expectancy would have to exceed 40 years.[2]

While the 1997 changes benefited all insurance carriers in the state of Alaska, health

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[2] We mistakenly advised the Committee last week that the cap on non-economic damages was the lesser of $1,000,000 or a multiplier of a person's life expectancy. After reviewing the statute, we realized our mistake. Our oversight underscores the rarity of any claim for non-economic damages exceeding that threshold.

care providers were given additional protection in the form of limiting expert witnesses who could testify on behalf of an injured Alaskan in medical malpractice actions.

A.S. 09.20.185 was enacted requiring that only board certified physicians having expertise and training directly related to the particular field or matter at issue would be allowed to testify regarding standard of care. This requirement is now necessary even though the offending doctor is not board certified in any practice group or specialty. Needless to say, this has made it even more difficult to obtain expert witnesses to testify against offending doctors, particularly since the same doctors belong to national organizations and often know each other personally.

In the face of these sweeping reforms, the insurance industry has repeatedly argued that tort reform benefits policyholders and the public at large. To date, there have been *no* reductions to my knowledge in any insurance rates charged to individual Alaskans. The current legislation that will benefit only health care providers will result in the same outcome. There will be no reduction in health care costs and no reduction in medical malpractice premiums charged in the state of Alaska. As discussed below, this has been repeatedly demonstrated throughout the United States.

THE HISTORY OF MALPRACTICE PREMIUMS IN ALASKA

To best illustrate this point, it is helpful to review the medical malpractice premiums charged in this state dating back to 1993 and compare those to California, the state much touted by the insurance industry because of its previously imposed caps on non-economic damages through the Medical Injury Compensation Reform Act (MICRA). Although the only published premium information readily available deals with the specialties of Internal medicine, General Surgery and OB/GYN, these seem to be the specialties of most concern at least by those physicians and health care providers who testified before the House Judiciary last week.[3]

A cursory review of the premiums charged illustrates the utter lack of credibility of the positions taken by this legislation's proponents. An important thing to remember when reviewing the premiums discussed below is that these are the amounts *charged* by the malpractice carriers. Both NORCAL and MIEC (the current and historical dominant carriers in the Alaska market) give credits back to their insureds. These credits are *not* reported in the data available but it is highly likely that these credits would further substantially reduce the published premiums paid by individual health care providers.[4]

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[3] Medical Liability Monitor [MLM] of Chicago publishes annual rate surveys from premium submissions provided by medical malpractice carriers or obtained directly from state insurance departments throughout the United States.

[4] MLM notes in all of its annual surveys that such credits, discounts and other factors can greatly diminish and sometimes completely offset rate increases. None of the surveys reflect this data, however.

In 1993, NORCAL's premium rates were $12,102 for Internal Medicine doctors, $37,750 for General Surgeons, and $64,518 for OB/GYN's. MIEC's premium rates for the same specialties were $5,487, $19,752, and $32,916 respectively. From 1994 through 1996, NORCAL's rates remained relatively stable. In 1994, MIEC raised its premiums for General Surgeons and OB/GYN's to $38,228 and $63,712 respectively. In 1995, MIEC reduced those rates by about 10 percent.[5]

Between 1997 and 1999, premium rates actually decreased significantly. NORCAL's rates dropped to $8,770 for Internal Medicine doctors, $28,587 for General Surgeons, and $48,706 for OB/GYN's. MIEC reduced its rates to $8,172, $29,420, and $49,032 respectively.[6]

There is no dispute that during this time frame and extending into 2001, most carriers in most states were reducing malpractice premiums because of intense competition in the industry. This competition was reflected in the state of Alaska by the joining of at least two other malpractice carriers to the competitive market.[7] The introduction of new carriers into the competitive market was a national phenomenon. Fierce competition continued to drive down rates for medical professional liability insurance in 1997.[8] In 1999, medical malpractice carriers had been battered from several years of brutal competition, with price cutting the name of the game, even when it meant selling *below* the break-even point.[9]

Back then, leaders in the industry were optimistic that the market would "harden" over the next three years.[10] Then vice president of Florida Physicians Insurance Company, Melodee Dixon, stated, "It will take that amount of time [three years] for claims on policies written at today's grossly inadequate rates to shake out."

Everyone in the industry during this time frame recognized that the amount of

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5 MLM annual surveys for 1993-1995.

6 MLM annual surveys for 1997-1999.

7 Although other carriers may have been in the Alaska market during this time frame, the only entities reporting premiums to MLM appear to be NORCAL, MIEC and joined in 1996 by Physicians Ins. Ex. of Washington and Doctors Co. in 1997. Northwest Physicians Mutual began reporting in 1999. It is unknown when CNA began writing coverage in Alaska.

8 MLM annual survey comments, 1997.

9 "Medical professional liability writers express a very pragmatic, but somewhat optimistic outlook about their market niche. Battered from several years of brutal competition, with price-cutting the name of the game, even when it means selling below the break-even point, these insurers nevertheless think that a market shake-out will come." MLM annual survey, 1999.

10 Market "hardening" is discussed, *infra.*

competition in the industry was causing drastic price cutting and exposing numerous carriers to significant financial risks in the future. These risks were self-inflicted and the resulting losses from malpractice claims were anticipated and predicted by competent actuaries.

The trend of lower malpractice premiums continued through 2000 in the state of Alaska. In 2001, as competition in Alaska and the national market waned, the predicted market "hardening" began to take form. Those carriers that had engaged in risky if not reckless underwriting began to pull out of markets in this state and across the United States. Notwithstanding, the malpractice premium rates in Alaska remained unchanged at MIEC through 2002 and were increased only slightly by NORCAL. In 2001, NORCAL raised its rates to $9,580 for Internal Medicine doctors, $30,872 for General Surgeons, and $52,600 for OB/GYN's.[11]

In 2003, with the market firmly "hardened," the rates from both carriers increased. NORCAL raised its rates for Internal Medicine doctors to $11,209, for General Surgeons to $36,122 and for OB/GYN's to $61,545. MIEC's premium rates were $7,432, $26,748, and $44,580 respectively. Notwithstanding, the premiums charged for 2003 were *less* than those charged by NORCAL for the same practice specialties in 1993, 1994, 1995, 1996 and only slightly higher than those charged in 1997 and 1998. The premium rates charged by MIEC in 2003 were less than those charged by the carrier in 1994, 1995, 1996, 1997, 1998, 1999, and only slightly higher than the premiums charged in 2001 and 2002.[12]

The significance of this rate comparison is even greater when comparing the discounted value of 2003 dollars with the previous years of lower premium rates. In short, these figures reflect an actual *reduction* in malpractice premiums over this time period when viewed in that light without considering the premium credits refunded to health care providers over this same time period. Moreover, when comparing these premiums to the inflation rate of health care costs (and resulting income to physicians), it is clear that these rates have not resulted in *any* increase to the cost of malpractice insurance premiums to health care providers in Alaska through 2003.

THE CALIFORNIA EXPERIENCE

Since California's non-economic damage cap legislation seems to be the model being touted by the proponents of this legislation, it is helpful to review the medical malpractice premiums charged in that state.

Between 1991 and 1997 In California, the medical malpractice premiums for internal medicine doctors, general surgeons and OB/GYNs remained relatively constant between 1991 and 1997. The premium rates charged by NORCAL over that time

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11 MLM annual survey 2000-2001.

12 MLM annual survey 2003.

period for Internal Medicine doctors ranged from $5,692 to $9,472, for General Surgecns, $18,916 to $29,440, and for OB/GYN's, from $31,624 to $49,208. MIEC's premium rates were $5,776, $20,792, and between $34,648 and $39,268 respectively.[13]

Of particular note, and as recognized by numerous commentators, the reason for the relative consistency over this time period had little or nothing to do with medical malpractice non-economic damage caps.

In 1975, California enacted the Medical Injury Compensation Reform Act (MICRA) that placed a cap of $250,000 on non-economic damages in medical malpractice actions. MICRA was touted by the insurance industry and health care practitioners as the solution to the "malpractice crisis" and the solution to increasing malpractice insurance rates. By 1988, however, medical malpractice premiums were 190% higher than 1976 levels (40% when adjusted for inflation to 2001 levels).[14]

In 1988 California voters passed Proposition 103, an insurance reform proposal. This proposition rolled back insurance rates 20% and froze rates for one year. It mandated billions of dollars worth of refunds to policyholders and created a system that required approval of insurance rates, allowing the insurance Commissioner to deny rate proposals that were too high or too low to be actuarially justified. It is following this proposition through 1996 that malpractice insurance rates actually stabilized.[15]

Beginning in 1997, insurance rates in California *again* began to increase substantially. In 1997, NORCAL's premium rates for Internal Medicine doctors ranged up to $9,472, for General Surgeons, up to $29,440 and for OB/GYN's, up to $49,208. The rates continued to increase slightly between 1999 and 2001. Since that time, through 2003, the rates have increased to ranges up to $25,178, $58,830, and $77,814 respectively. During this same time period, MIEC's premium rates have increased from their 1996 -- 1998 rates to a range up to $9,305, $27,682, and $50,340 respectively. Accordingly, even with MICRA reform, malpractice rates have steadily *risen* in California and are comparable to or substantially greater than malpractice premium rates charged in this state by the same companies notwithstanding the lack of additional caps on non-economic damages.[16]

THE INSURANCE INDUSTRY ADMITS THAT CAPS WILL NEITHER REDUCE PREMIUMS NOR ARE CAPS RELATED IN ANY WAY TO THE AVAILABILITY OF HEALTH CARE

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13 MLM annual surveys, 1991-1997.

14 *How Insurance Reform Lowered Doctors Medical Malpractice Rates in California*, The Foundation for Taxpayer and Consumer Rights, February 10, 2003, excerpted from N.C. trial lawyers expose on malpractice rates in N.C.

15 *Id.*

16 MLM annual surveys, 1996-2003.

Misinformation regarding the efficacy of caps on non-economic damages and purported decreases in medical malpractice premiums has been disseminated by health care providers and malpractice insurers in other states as well.

In Florida, after pushing through a sweeping medical malpractice bill in August with a promise to reduce ever-increasing insurance premiums for Florida's physicians, malpractice insurance carriers followed up the bill's passage with a request to increase premiums by as much as 45 percent.[17]

In 2003, Oklahoma passed a tort reform bill that included a severe cap on compensation available to certain medical malpractice victims. Following passage of that bill, the insurance company owned by the state medical association requested an astounding 83 percent rate hike which was subsequently approved on the condition that it be phased-in over three years.[18]

In January 2003, Ohio lawmakers enacted a cap on compensation for patients injured by medical malpractice. Almost immediately, all five major malpractice insurance companies in Ohio announced that they would not reduce their rates. One insurance executive predicted his company would seek a 20 percent rate increase.[19]

This should come as no surprise to those familiar with the insurance industry and particularly with malpractice carriers.

Bob White, president of First Professional Insurance Co., the largest medical malpractice insurer in Florida stated that "no responsible insurer can cut its rates after a [medical malpractice tort reform] bill passes."[20] Cliff Webster representing the Washington State Medical Association and Chairman of the Washington Liability Reform Coalition told the Washington State Legislature, House Judiciary Committee in 2003 that "I don't think we would argue that the premiums are likely to go down."[21]

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17 *See, e.g.*, Julie Kay, "Medical Malpractice; Despite Legislation that Promised to Rein in Physicians Insurance Premiums, Three Firms File For Big Rate Increases," *Palm Beach Daily Business Review*, Nov.20, 2003.

18 *BestWire*, Dec. 2, 2003.

19 Laura Bischoff, "Taft Signs Malpractice Reform Bill; Cap on Awards for Pain and Suffering," *Dayton Daily News,* Jan. 11, 2003; Andrew Welsh-Huggins, "Doctors Pushing for Short-Term Relief From Malpractice Rates," *Associated Press*, Jan. 10, 2003; "Despite New Law, Insurance Companies Won't Lower Rates Right Away," *Associated Press*, Jan. 9, 2003.

20 *Palm Beach Post*, Jan. 29, 2003.

21 Testimonial excerpt from testimony before the Washington State Legislature, House Judiciary, Feb. 21, 2003.

Sherman Joyce, President of the American Tort Reform Association candidly acknowledged, "We wouldn't tell you or anyone that the reason to pass tort reform would be to reduce insurance rates."[22] James Robertson, Assistant Vice President and Associate Actuary for SCPIE Indemnity Company (California's second largest medical malpractice insurer) stated "while MICRA was the Legislature's attempt at remedying the medical malpractice crisis in California in 1975, it did not substantially reduce the relative risk of medical malpractice insurance in California." He made that statement in a written response to a question from an administrative law judge overseeing the case in which his company had requested another 15.6% rate hike.

In short, virtually every reliable empirical source underscores the certainty that limiting an injured persons access to the court system for damages has little or nothing to do with insurance premiums for the cost of health care delivery.

In January 2004, the Congressional Budget Office (CBO) concluded that legislation to cap damages in medical malpractice lawsuits would do little to hold down health care spending or eliminate the practice of defensive medicine. Moreover, the report found that medical malpractice insurance premiums have increased in part because of reduced income from insurer investments and short-term factors in the insurance market. The report found that although malpractice insurance premiums are somewhat lower in states with caps on damages, even a large savings in premiums would have a small impact on total health care spending because malpractice insurance costs account for less than two percent of health care spending. The CBO concluded that caps on damages in malpractice suits would not likely end the practice of defensive medicine. That is because physicians who practice defensive medicine may do so less because they fear liability than to generate more income. Equally compelling, the GAO concluded that many reported shortages of health care services [based on these factors] could not be substantiated or did not widely affect access to health care.[23]

In a sweeping and thorough investigation for AIR under the direction of Mr. Robert Hunter (former Federal Insurance Administrator and Texas Insurance Commissioner) it was determined that insurers make most of their profits from investment income. During years of high interest rates or excellent returns in the market, insurance

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22 "Study Finds No Link Between Tort Reforms and Insurance Rates," *Liability Week*, July 19, 1999.

23 *Congress Daily,* Jan. 13, 2004. The same argument of "fleeing" doctors and fear of inability to attract new ones has been completely debunked in Washington. Doctors for Medical Liability Reform claimed that 500 doctors had left the state between 1998 and 2004. They failed to mention, and did not research, however, how many doctors had moved to Washington over the same time frame. According to the 2003 GAO report, there were more doctors per capita in 2001 than in 1998. Moreover, despite arguments to the contrary, there was no indication that health care delivery was being curtailed or eliminated. Carol Ostrom, "Contrary to Ads, Doctors Replaced, Clinics Still Open," *Seattle Times*, Feb. 23, 2004.

companies engaged in fierce competition for premium dollars to invest and maximum returns. They severely under price premiums for policies and insure very poor risks to get premium dollars to invest. This is known as the "soft" insurance market. When the investment climate turns sour, however, the industry responds by sharply increasing premiums and reducing coverage, creating a "hard" insurance market, usually degenerating into a "liability insurance crisis."[24] This is precisely what is proven conclusively by reviewing the comments and premium surveys discussed above.

Moreover, the Hunter report concluded that since the early 1980's, medical malpractice paid claims per doctor has tracked (approximately) medical inflation. In fact, inflation-adjusted payouts for physicians dropped between 2000 and 2002.[25] This data confirms that neither jury verdicts nor any other factor affecting total claims paid by insurance companies that write medical malpractice insurance have had much impact on the system's overall costs over time. Even more compelling, since 1975, the data shows that in terms of constant dollars, per doctor written premiums, the amount of premiums that doctors have paid insurers have gyrated almost precisely with the insurer's economic cycle which is (again) driven by such factors as changing insurance rates, mismanaged business and accounting practices as well as other causes.[26]

MEDICAL MALPRACTICE IN ALASKA – THE REALITY

In summary, what is being touted as a basis for the passage of this legislation is without merit. The following facts underscore why this legislation is bad for Alaskans.

1. Fact: Citizens who are elderly or retired, citizens living a subsistence lifestyle, stay at home parents, and children will be without any legal remedy for even the most egregious instances of medical malpractice. Since they have little or no economic loss, they will not be able to obtain legal counsel to pursue a medical malpractice claim even if they are blinded, crippled, maimed, rendered sexually dysfunctional, or die after a sustained period of suffering. The cost of bringing such claims will easily exceed any potential recovery.

Real-Life Examples:

Linda McDougal -- this is the much-publicized case involving the 46-year-old Navy veteran who underwent a double mastectomy after mistakenly being diagnosed with an aggressive breast cancer. Her pathology results had been mistakenly switched with another woman who in fact had breast cancer. This woman is now horribly scarred for

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[24] Americans for Insurance Reform, Medical Malpractice Insurance: Stable Losses/Unstable Rates in Wyoming, Feb. 2004.

[25] *Id.*

[26] *Id.*

life.

Jennifer -- Jennifer was a beautiful and vibrant 12-year-old Alaskan who was misdiagnosed twice over a three-day period with gingivitis. She was actually suffering from acute leukemia, which was very treatable and survivable but requires a timely diagnosis and urgent medical intervention. This could have been determined with a simple and inexpensive blood test. Unfortunately, given the delay in her diagnosis, she hemorrhaged and died before she could be properly diagnosed. Although this was a clear-cut case of negligence, over $100,000 in out-of-pocket costs were expended before the case settled. Under the proposed legislation, this case could never have been prosecuted and Jennifer, her parents, and three siblings would have been without any remedy at all.

Susan -- Susan was an Alaskan in her early 30's when she was misdiagnosed and refused treatment by several health care providers over a five-day period. Unfortunately, she was suffering from a well-known medical and orthopedic emergency known as cauda equina syndrome. By the time she was finally correctly diagnosed, she had suffered permanent saddle anesthesia (no feeling from her waist to her mid thigh); permanent lower extremity neurological injuries requiring leg braces; and intermittent bowel and bladder dysfunction. Under this legislation, since she could still work at her profession, she would be left with a remedy of $250,000. Despite clear-cut negligence, costs of over $200,000 were expended before settlement was reached.

Traven -- Traven was an adventurous eight-year-old Alaskan boy who sustained lower extremity burns that were entirely survivable and treatable. Unfortunately, due to a series of medical mistakes, he languished for days with an increasingly more severe infection and ultimately lapsed into a coma (with his parents present). He was finally flown to Seattle Children's Hospital where he died. Under this legislation, it would be financially difficult or impossible to bring this claim since his entire family, like Jennifer's above, as well as his estate would be limited to $250,000 in non-economic damages. Although an economic loss to his estate could be claimed, those losses are more difficult to establish for children and are usually so low as to not warrant prosecution of a claim absent non-economic damages.

Mrs. Strong -- Mrs. Strong was a 32-year-old Alaskan mother of two children who was drastically over dosed with a highly caustic chemotherapy drug. The overdose was approximately 8 times what she was supposed to be given and was repeatedly administered over the course of 4 days. She died a horrible death, essentially burning up from the inside out over the course of 6 days. She never had a chance to say goodbye to her children, husband, or her parents. Since she was a mom and essentially out of the work force, she would have had little economic loss and, under this bill, her estate and entire family would be limited to $250,000 in losses.

These are only a few of the many actual cases that we can provide this committee as concrete examples of why this bill works such gross inequities on the innocent people in

correction!!

Americans die annually from medical errors in hospitals. On December 12, 2002, the New England Journal of Medicine reported that 4 out of 10 Americans and 1 out of 3 doctors say that they or their family members have been the victims of a preventable medical error; 10% of doctors say that a family member died as a consequence.[28] How will this legislation address these problems other than to make it financially easier on negligent health care providers and their insurance carriers?

should be 7%

Fact: Repeat offender physicians are responsible for most medical errors. According to a study recently conducted in North Carolina, 3.2% of North Carolina doctors had paid out two or more medical malpractice settlements to patients but were responsible for a total of nearly 42% of all payments reported to the National Practitioner Data Bank.[29] A study conducted by researchers at Vanderbilt University found that doctors with a history of malpractice claims can be expected to have "appreciably worse claims experience" than other doctors in the future.[30] This legislation would protect those health care providers by sharply limiting their exposure for continued malfeasance.

Fact: Medical Malpractice insurance costs are declining as a percentage of physician expenses. A recent USA Today report stated that, on average, doctors currently pay 3.2% of their revenue for medical liability insurance.[31] In 1987, medical malpractice insurance costs were, on average, 12.1% of the physician's total expenses. In the ensuing decade that share was cut in half, falling to less than 7% of total expenses in the late 1990's. Based on the most current statistics available from the American Medical Association, there is a clear and consistent decline in medical malpractice costs as a percentage of a physician's total expenses.[32]

In conclusion, this is without a doubt the most offensive example of self-interest legislation proposed in the last 25 years in Alaska. It is utterly without any reliable factual support for the premise of its proposed utility. It will only serve to benefit the insurance industry and those physicians who engage in negligent and sometimes reckless misconduct. While there are relatively few cases filed in this state alleging medical malpractice, this legislation will severely impact if not entirely eliminate a substantial portion of legitimate and worthy claims. It will leave horrifically injured

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28 *New England Journal of Medicine*, December 12, 2002.

29 *Medical Misdiagnosis in North Carolina*, Public Citizens Congress Watch, April 2003.

30 "Medical Malpractice Experience of Physicians: Predictability or Haphazard?" *Journal of the American Medical Association*, 1989–cited in Medical Misdiagnosis, *Id.*

31 "Hype Outraces Facts in Malpractice Debate," *USA Today*, March 3, 2003.

32 American Medical Association, *Socioeconomic Characteristics of Medical Practice*, 2000 as quoted from N.C. trial lawyer expose.

our State who are the most vulnerable. If you would like to hear about them, please advise and we will provide additional summaries.

Fact: The passage of this legislation will have no impact on medical malpractice premiums in this state and will have no impact on the ability to attract health care professionals to practice here. Other than anecdotal and unsupported comments to the contrary, there is absolutely no evidence to suggest that health care providers stay away from Alaska because of medical malpractice insurance premiums. Indeed, it is considered one of the top 75 places in the United States to practice medicine.[27] This is based in no small part on the lack of managed-care. Further, according to the State Medical Board, the number of medical board licensees has more than doubled since 1985.[28] As discussed above, the argument that the lack of caps discourages doctors from practicing has been posited and rejected by the CBO and others.

Fact: The Institute of Medicine reported three years ago that as many as 98,000 Americans die annually from medical errors in hospitals. On December 12, 2002, the New England Journal of Medicine reported that 4 out of 10 Americans and 1 out of 3 doctors say that they or their family members have been the victims of a preventable medical error; 10% of doctors say that a family member died as a consequence.[29] How will this legislation address these problems other than to make it financially easier on negligent health care providers and their insurance carriers?

Fact: Repeat offender physicians are responsible for most medical errors. According to a study recently conducted in North Carolina, 3.2% of North Carolina doctors had paid out two or more medical malpractice settlements to patients but were responsible for a total of nearly 42% of all payments reported to the National Practitioner Data Bank.[30] A study conducted by researchers at Vanderbilt University found that doctors with a history of malpractice claims can be expected to have "appreciably worse claims experience" than other doctors in the future.[31] This legislation would protect those health care providers by sharply limiting their exposure for continued malfeasance.

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27 Modern Physician, "The List" www.modernphysician.com.

28 Chart "Total Medical Board Licensees by Fiscal Year, 1985-2003. Division of Occupational Licensing

29 *New England Journal of Medicine*, December 12, 2002.

30 *Medical Misdiagnosis in North Carolina*, Public Citizens Congress Watch, April 2003.

31 "Medical Malpractice Experience of Physicians: Predictability or Haphazard?" *Journal of the American Medical Association*, 1989--cited in Medical Misdiagnosis, *Id.*

currently pay 3.2% of their revenue for medical liability insurance.[32] In 1987, medical malpractice insurance costs were, on average, 12.1% of the physician's total expenses. In the ensuing decade that share was cut in half, falling to less than 7% of total expenses in the late 1990's. Based on the most current statistics available from the American Medical Association, there is a clear and consistent decline in medical malpractice costs as a percentage of a physician's total expenses.[33]

Fact: Medical malpractice cases make up a very small percentages of cases filed in Alaska.

Fact: Most medical malpractice verdicts in Alaska are in favor of the defendant doctor. In the history of Alaska there is only one jury verdict against health care providers that was over one million dollars.

In conclusion, this is without a doubt the most offensive example of self-interest legislation proposed in the last 25 years in Alaska. It is utterly without any reliable factual support for the premise of its proposed utility. It will only serve to benefit the insurance industry and those physicians who engage in negligent and sometimes reckless misconduct. While there are relatively few cases filed in this state alleging medical malpractice, this legislation will severely impact if not entirely eliminate a substantial portion of legitimate and worthy claims. It will leave horrifically injured patients and their families with a lifetime of misery, pain, and suffering with no remedy.

There is a substantial statistical chance that this legislation will affect one or more of you or a member of your family on a very personal basis during your lifetime. When you consider that it is estimated by health care safety monitors in Alaska that over 30 percent of providers don't even wash their hands before examining a patient, the chances of negligently passing on infectious disease is very high. [34] At least consider your safety and the safety of others before passing this grossly unfair legislation.

Very Truly Yours,

The Alaska Action Trust
Melissa Fouse, Executive Director

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32 "Hype Outraces Facts in Malpractice Debate," *USA Today*, March 3, 2003.

33 American Medical Association, *Socioeconomic Characteristics of Medical Practice*, 2000 as quoted from N.C. trial lawyer expose.

34 Anchorage Daily News, March 2, 2004, Page D-1 "Patient Power"

HEALTHCARE

- Main Page
- Press Releases
- In the Media
- Factsheets
- Reports
- Medical Malpractice Stories
- HMO Arbitration Abuse Report
- Casualty of the Day

OTHER TOPICS

- Corporate Accountability
- Insurance
- Citizen Advocacy
- The Justice System
- Billing Errors
- Energy
- About FTCR

Read Book About HMO Abuses Online

home / healthcare / factsheets

FACTSHEET

Five Dangerous Myths About California's Medical Malpractice Restrictions

Myth#1: Legal Restrictions on Victims Lowered California Doctors' Malpractice Premiums.

Facts: Californians enacted the strongest insurance rate regulation in the nation in 1998 through insurance reform Proposition 103 (Prop 103), a ballot initiative passed by the voters and authored by FTCR president Harvey Rosenfield. This law resulted in a rate freeze, a rate rollback, and stringent regulation that reduced premiums in all lines of insurance -- including medical malpractice.

In 1975, California enacted a series of legal restrictions on injured patients -- the Medical Injury Compensation Reform Act (MICRA). Data from the National Association of Insurance Commissioners, summarized in graphs linked to below show that:

- Overall, California medical malpractice premiums increased dramatically during the first thirteen years with MICRA and substantially decreased after voters' approved Proposition 103. (See graph)
- Medical malpractice premiums remained extremely volatile after MICRA and did not stabilize until Prop 103 imposed rate regulation in 1988.
- In 1986, after a decade of MICRA, California was once again mired in an insurance crisis, with medical malpractice premiums rising at a rate of 26% annually, faster than premiums rose nationally during the same period. In fact, the year MICRA's cap of damages was upheld in court (1985), California malpractice premiums increased by 20% and the following year rates jumped an additional 40%.
- Conversely, after three years of insurance regulation under Prop 103, medical malpractice rates had fallen by more than 20%. During the first decade of regulation, premiums were down by 7% and, if we adjust for inflation, medical malpractice premiums are down by 35% since the enactment of regulation.

- California medical malpractice premiums tracked closely with national trends until Proposition 103 set California apart, by statutorily requiring lower insurance rates. (See graph)

Former Governor Jerry Brown, who signed the MICRA law, stated seventeen years later (on June 13, 1993) that he would not recommend it for the nation because in the interlude he "witnessed yet another insurance crisis and found that insurance company avarice, not utilization of the legal system by injured consumers was responsible for excessive premiums." "Saddest of all," Brown continued, is "the arbitrary and cruel effect upon victims of malpractice." (Read Brown's full statement)

Myth #2: Injured patients are still able to hold wrongdoers legally accountable because only "non-economic" damages are capped -- compensation for those damages not measured by wage loss, medical bills, or other tangible economic measures.

Facts: Only those patients with large wage loss or medical bills are typically able to find attorneys in California. Most medical malpractice victims cannot. For example, injured patients who, as a result of medical negligence, lose their fertility or are severely disfigured typically cannot prove "economic" damage. Similarly, the death of a child or senior citizen typically does not result in "economic" damage because there is no basis for wage loss or measuring medical bills. In these types of California cases, there is typically no legal accountability for wrongdoers

The situation stirred well-known insurance defense attorney Robert Baker, who defended malpractice suits for more than twenty years, to tell Congress about the problem. "In my view, these malpractice reforms have aided insurance companies and physicians, but have, to a significant extent, been detrimental to person injured by medical negligence," Baker testified before the House Judiciary Committee in 1994 on behalf of the American Board of Trial Advocates (ABOTA). "As a result of the caps on damages, most of the exceedingly competent plaintiff's lawyers in California simply will not handle a malpractice case.

"There are entire categories of cases that have been eliminated since malpractice reform was implemented in California. The victims of cases that have a value between $50,000 and $150,000 are basically without representation. As an example, incidents of failure to diagnose an appendicitis still occur, but suits are not filed to any extent in California."

Soon after the testimony, Baker's major clients -- the HMO Kaiser Permanente and malpractice insurer The Doctors' Company -- fired him. (Read Baker's full statement)

Legal fees and expenses are not added on to the "economic" damage award, so they must be subtracted from the capped "non-economic" damages portion. This makes expensive cases without significant economic damage components not viable for attorneys.

Myth #3 A one-size-fits-all cap on compensation is fair to patients who can receive "unlimited" economic damages.

Facts: Economic damages cannot always be anticipated. California juries are not informed of the cap on non-economic damages, so they are often not careful about apportioning economic damages. In one famous case, for example, Harry Jordan, a Long Beach man, was hospitalized to have a cancerous kidney removed but the surgeon took out his healthy kidney instead. A jury awarded Jordan more than $5 million dollars, but the judge was required to reduce the verdict to $250,000 due to California's cap on "non-economic" damages - plus a mere $6,000 in "economic costs". Jordan, who lived for years on 10% kidney function, could no longer work, though the jury (which lawfully can not be notified about the "non- economic" cap) did not take this into account. Jordan's court costs -- not including attorney fees -- amounted to more than $400,000 and his medical bills, that arose after frequently being denied by insurers, totaled more than $500,000. He paid $1700 per month in health insurance.

The stories of other patients victimized by California's restrictions can be found in FTCR's testimony before Congress.

Read a letter from members of California's Congressional Delegations critical of MICRA.

Myth #4: Malpractice damage caps are about doctors vs. lawyers .

Facts: Malpractice caps are about patients vs. reckless HMOs and managed care corporations.

Twelve years old today, Steven Olsen is blind and brain damaged because, as a jury ruled, he was a victim of medical negligence when he was two years old. He fell on a stick in the woods while hiking. Under the family's HMO plan, the hospital pumped Steven up with steroids and sent him away with a growing brain abscess, although his parents had asked for a CAT scan because they knew Steven was not well. The next day, Steven Olsen came back to the hospital comatose. At trial, medical experts testified that had he received the $800 CAT scan, which would have detected a growing brain mass, he would have his sight and be perfectly healthy today.

The jury awarded $7.1 million in "non-economic" damages for Steven's avoidable life of darkness and suffering. However, the jury was not told of the two decade old restriction on non-economic damages in the state. The judge was forced to reduce the amount to $250,000. The jurors only found out that their verdict had been reduced by reading about it in the newspaper. Jury foreman Thomas Kearns expressed his dismay in a letter published in the San Diego Union Tribune.

"We viewed video of Steven, age 2, shortly before the accident. This beautiful child talked and shrieked with laughter as any other child at play. Later, Steven was brought to the court and we watched as he groped, stumbled and felt his way along the front of the jury box. There was no chatter

or happy laughter. Steven is doomed to a life of darkness, loneliness and pain. He is blind, brain damaged and physically retarded. He will never play sports, work, or enjoy normal relationships with his peers. His will be a lifetime of treatment, therapy, prosthesis fitting and supervision around the clock. . . Our medical-care system has failed Steven Olsen, through inattention or pressure to avoid costly but necessary tests. Our legislative system has failed Steven, bowing to lobbyists of the powerful American Medical Association (AMA) and the insurance industry, by the Legislature enacting an ill-conceived and wrongful law. Our judicial system has failed Steven, by acceding to this tilting of the scales of justice by the Legislature for the benefit of two special- interest groups. . .. I think the people of California place a higher value on life than this."

In 2001, Steven had 74 doctor visits, 164 physical and speech therapy appointments, and three trips to the emergency room. And his parents say that was a good year because Steven was not hospitalized. Steven's mother Kathy had to leave her job because caring for Steven is a full time job. She has to struggle constantly with the school district for Steven to receive special education classes. One day, Steven ate part of a light bulb, not an uncommon problem for children with brain injuries. He has to be watched constantly. Insurance executives that seek to limit jury awards for the individual's pain and suffering claim society must do so to save money. Yet these executives typically make millions every year without any of Steven Olsen's pain and suffering. Limiting their responsibility for the pain of individuals reduces not only the corporation's accountability, but the worth of the individual to that of a mere object.

Kathy Olsen said this about Steven: "It has been 10 years ago this month when Steven came home from a 5-month life changing stay at the hospital. He was only 2 years old. When he went into the hospital no one asked his party affiliation. He was a casualty of the system. The system that he had no say in. Which lawmakers were looking out for him? Now with all his disabilities he will never see, do things that the average person gets to do in their lifetime, or vote in an election. Please look out for all the Steven Olsens in this great country. Don't let this happen over and over again."

Myth #5 Defensive medicine is always bad, significantly drives up the costs of medicine and results from doctors facing full legal accountability.

Facts: In the managed care age, the financial incentives point the other way -- to less caution, not more. Proponents of limiting victims' rights claim that doctors' fear of lawsuits, so called defensive medicine, is driving them to perform unnecessary tests and procedures.

The Congressional Office of Technology Assessment foresaw this trend in July 1994, reporting that less than 8 percent of diagnostic procedures are likely to be caused by conscious concern about malpractice liability. "Defensive medicine is not always bad for patients," the agency stated. "Malpractice reforms that remove incentives to practice defensively, without differentiating between appropriate and inappropriate defensive medicine, could also remove a deterrent to providing too little

care at the very time that such mechanisms are needed."

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back to top

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Patient Power

National groups and Alaska watchdogs encourage consumers to question health care providers

By ANN POTEMPA
Anchorage Daily News
(Published: March 2, 2004)

NEXT TIME YOU PAY A VISIT TO YOUR DOCTOR, ask questions.

Here's one to start with: "Did you wash your hands?"

Patients may take it for granted that doctors and nurses head to the sink before each exam, but local hospitals admit some of their employees don't. At one, a study showed that about a third of the staff wasn't washing up.

This new approach is a healthy self-defense for patients. It's a shift away from automatically trusting that the folks in scrubs and stethoscopes always do the right thing. This year, a national hospital accreditation agency gave consumers some muscle by creating seven National Patient Safety Goals that hospitals must meet (see list at left).

Too often, patients think: "Gosh, they're a *hospital.* They know what they're doing," said Dr. Norman Wilder, one of the founding members of Alaska's Patient Safety Collaborative, a group of patient safety advocates from medical facilities around the state.

But medical professionals make mistakes. Intentional or not, they can be deadly. An Institute of Medicine report in 1999 concluded that mistakes made in hospitals cause more deaths nationwide than do car accidents, breast cancer or AIDS. The report, "To Err Is Human: Building a Safer Health System," drew from studies of Utah, Colorado and New York hospitals. Alaska was not a focus of the study, but the error rates from participating states were extrapolated over total U.S. hospital admissions in 1997. The institute estimated that errors killed 44,000 to 98,000 people every year.

National agencies and Alaska's own advocates are coming up with new ways to help lower those numbers. Alaska's group is giving patients stickers that tell them to question their doctors. They're asking doctors to wear stickers that say they welcome inquiries.

Members of the collaborative talked about a recent serious error on the East Coast. Last year, a teen girl died after a medical team at Duke University Hospital performed a heart-lung transplant on her using an organ donor with the wrong blood type.

Alaska's collaborative didn't just point fingers Outside. Medical staff here admitted to giving the wrong drugs to patients. From now on, staff have to find two ways to correctly identify each patient before giving medications or taking blood. It's no longer acceptable to allow patients to simply nod "yes" when a doctor asks if they go by a certain name; patients might be stressed or tired and nod

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SPECIAL ARTICLE

PATIENT SAFETY

◂ Previous Volume 347:1933-1940 December 12, 2002 Number 24 Next ▸

Views of Practicing Physicians and the Public on Medical Errors

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ABSTRACT

Background In response to the report by the Institute of Medicine on medical errors, national groups have recommended actions to reduce the occurrence of preventable medical errors. What is not known is the level of support for these proposed changes among practicing physicians and the public.

Methods We conducted parallel national surveys of 831 practicing physicians, who responded to mailed questionnaires, and 1207 members of the public, who were interviewed by telephone after selection with the use of random-digit dialing. Respondents were asked about the causes of and solutions to the problem of preventable medical errors and, on the basis of a clinical vignette, were asked what the consequences of an error should be.

Results Many physicians (35 percent) and members of the public

ARTICLE
- Table of Contents
- Abstract of this article
- PDF of this article
- PDA version of this article
- Editor's Summary
- Related Letters to the Editor

Related editorials in the Journal:
- Lee, T. H.
- Find Similar Articles in the Journal
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- Related Articles
- Citing Articles (33)

Special Article

PATIENT SAFETY

VIEWS OF PRACTICING PHYSICIANS AND THE PUBLIC ON MEDICAL ERRORS

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Results Many physicians (35 percent) and members of the public (42 percent) reported errors in their own or a family member's care, but neither group viewed medical errors as one of the most important problems in health care today. A majority of both groups believed that the number of in-hospital deaths due to preventable errors is lower than that reported by the Institute of Medicine. Physicians and the public disagreed on many of the underlying causes of errors and on effective strategies for reducing errors. Neither group believed that moving patients to high-volume centers would be a very effective strategy. The public and many physicians supported the use of sanctions against individual health professionals perceived as responsible for serious errors.

Conclusions Though substantial proportions of the public and practicing physicians report that they have had personal experience with medical errors, neither group has the sense of urgency expressed by many national organizations. To advance their agenda, national groups need to convince physicians, in particular, that the current proposals for reducing errors will be very effective. (N Engl J Med 2002;347:1933-40.)

THE prevention of serious errors in medical care has long been of concern to health professionals, as well as courts and legislatures.[1] However, the recent report by the Institute of Medicine (IOM), *To Err Is Human*, focused attention on the problem, particularly its conclusion that, each year, more Americans die as a result of medical errors made in hospitals than as a result of injuries from automobile accidents.[2,3] At the time the report was released, a survey showed that half the American public followed the media coverage of it.[4] Since then, there have been many new efforts to reduce the incidence of medical errors.[5-10] However, there are those who disagree with the report's conclusions, arguing that the report overstated the magnitude of the problem.[11-14]

Still not known are the views of practicing physicians and the public with regard to both the number of deaths due to errors and the recommendations of national groups for reducing these errors. Many of the recommendations would change the daily practice of individual physicians and hospitals, so the support of practicing physicians may be crucial. New legislation and changes in public policy may require the backing of both physicians and the public.[15-18]

We conducted parallel surveys of physicians and the public to learn their views on medical errors. We posed the following questions: Have you had a personal experience with medical errors made in your care or that of a family member? How frequent and how serious is the problem of medical errors as compared with other problems in health care? What are the most important causes of medical errors? What actions should be taken to prevent medical errors? What should be the consequences for a health professional or institution involved in a medical error?

From the Department of Health Policy and Management, Harvard School of Public Health, Boston (R.J.B., C.M.D., J.M.B., A.B.R., E.S.); the Kaiser Family Foundation, Menlo Park, Calif. (M.B., D.E.A., A.E.S.); Harris Interactive, Rochester, N.Y. (K.Z.); and ICR/International Communications Research, Media, Pa. (M.J.H.). Address reprint requests to Dr. Blendon at the Harvard School of Public Health, Health Policy and Management, 677 Huntington Ave., Boston, MA 02115.

METHODS

Study Design

A team of researchers from the Harvard School of Public Health and the Kaiser Family Foundation designed and analyzed both surveys. They were conducted in the United States.

Physicians

The fieldwork for the survey of physicians was conducted by Harris Interactive. The sample was randomly selected from the national list of physicians provided by Medical Marketing Service. This list, which includes both physicians who are members of the American Medical Association and nonmembers, is updated weekly. A questionnaire was mailed to 1332 physicians along with a check for $100 as an incentive for completing it. The survey was conducted between April 24 and July 22, 2002. A total of 831 physicians either completed the questionnaire on paper and returned it by mail (777) or completed and submitted it online (54). The response rate was 62 percent.[19] The margin of error was ±3.5 percentage points.

The General Public

A total of 1803 members of the public were contacted and deemed eligible for the national telephone survey, performed with random-digit dialing; 1207 adults (18 years of age or older) completed the survey. It was conducted in Spanish and English by International Communications Research between April 11 and June 11, 2002. Respondents were not given a financial incentive to participate. The response rate was 67 percent.[19] The margin of error was ±2.6 percentage points.

The Survey Questionnaire

To conduct parallel surveys, a single questionnaire was developed and modified to be appropriate for each group of respondents. The questionnaire was reviewed by physicians and experts in medical errors and was then pretested for length and comprehensibility. Both surveys were revised on the basis of the results of these tests. Twenty-nine questions were included in the survey of physicians and 38 in the survey of the public; 8 questions in each instrument had multiple parts. The questions focused on inpatient errors, since the majority of proposals address such errors.

The questionnaire asked whether an error had ever been made in the respondent's own care or that of a family member and, if so, what the health consequences of that error had been. Respondents were asked to state in their own words what they considered to be the two most important problems with health care and medicine. The responses were grouped in categories, one of which was medical errors. No respondents in the survey of the public and few in the survey of physicians used the term "medical error" when answering the question. Most respondents used terms such as "incompetent doctors" and "mistakes."

After answering the open-ended question, respondents in both surveys were given the following statement defining "medical error" to ensure that they had a common understanding of the term: "Sometimes when people are ill and receive medical care, mistakes are made that result in serious harm, such as death, disability, or additional or prolonged treatment. These are called medical errors. Some of these errors are preventable, whereas others may not be."

Respondents were asked how many in-hospital deaths they thought resulted from preventable medical errors each year. They were given a choice of five numbers from 500 to 500,000 or more. Among the choices were the IOM's higher estimate of 98,000 (rounded to 100,000), the IOM's lower estimate of 44,000 (rounded to 50,000), and the estimate of 4500 (rounded to 5000) made by another team of researchers using a different set of assumptions.[12] We also asked respondents to rate the importance of 11 factors that might contribute to medical errors and the effectiveness of 16 possible solutions.

We asked the following question about high-volume centers: "Suppose a patient needs a specialized medical procedure. This person can choose either a hospital that does a large number of these procedures or a hospital that does not do as many. At which hospital do you think this patient would be more likely to have a preventable medical error made in his or her care, or wouldn't it make a difference?"

The questionnaires included the following vignette, developed by physicians[20]: "A 67-year-old man goes to the hospital for surgery. He has an allergy to antibiotic drugs, which is noted on his medical record. The surgeon does not notice the information about the allergy and orders an antibiotic to be given at the end of the surgery. A hospital nurse gives the patient the antibiotic." To examine the hypothesis that respondents' views on the appropriate consequences for the health professionals would vary according to the severity of the error's outcome, we randomly varied the health consequences for the patient. Half of each group of respondents were told that the patient was harmed: "The patient wakes up with a rash all over his body and is gasping for air. The mistake is noticed, and the antibiotic is stopped, but the patient stops breathing. Despite every effort, the patient dies." The other half were told that the patient was not harmed: "The patient wakes up with a rash all over his body. The mistake is noticed, the antibiotic is stopped, and the patient fully recovers." The physicians were told that the language of the vignette had been simplified so that laypeople would understand it.

Statistical Analysis

We compared responses by testing differences between proportions, using Fisher's exact test. The statistical program that we used took into account the design effects for each of the surveys by calculating the effective sample size. Because previous research has shown that the salience of an issue is an important factor in the level of support for change, we limited analyses of graded responses to the proportion of respondents who said that a cause of errors was "very important" or that a solution would be "very effective."[21] All reported P values are based on two-sided tests.

To adjust for sampling biases due to sociodemographic differences in nonresponse rates and to ensure that the sample was representative, survey responses were weighted by computer with the use of a predetermined weighting scheme. The data in the survey of the public were weighted on the basis of the latest U.S. Census numbers for sex, age, race or ethnic group, level of education, number of people in the household, and number of land telephone lines. The data in the survey of physicians were weighted for region, specialty, training (foreign vs. U.S.), and number of years since graduation from medical school. There were no qualitative differences between unweighted and weighted results.

RESULTS

Experiences with Medical Errors

Thirty-five percent of physicians and 42 percent of the public reported that they had experienced an error in their own care or that of a family member (Table 1). Eighteen percent of physicians and 24 percent of the public reported an error that had had serious health consequences, including death (reported by 7 percent of physicians and 10 percent of the public), long-term disability (6 percent and 11 percent, respectively), and severe pain (11 percent and 16 percent, respectively). About a third of the respondents in both groups who reported experience with an error said that the health professionals involved in the error had told them about it or apologized to them.

Seventy percent or more of both groups of re-

TABLE 1. RESPONDENTS' PERSONAL EXPERIENCE WITH PREVENTABLE MEDICAL ERRORS.

RESPONSE	PHYSICIANS (N=831)	PUBLIC (N=1207)	P VALUE
	percent		
All respondents			
Error made in own or family member's care	35	42	<0.001
Health consequences			
Serious	18	24	<0.001
Minor	10	13	0.03
None	7	5	0.06
Serious consequences			
Severe pain	11	16	<0.001
Substantial loss of time at work or school, or in other important activities	12	17	<0.001
Temporary disability	8	12	0.009
Long-term disability	6	11	0.003
Death	7	10	0.01
Respondents reporting an error*			
Parties who had "a lot" of responsibility for the error			
Doctors	70	81	<0.001
Nurses	25	25	0.15
Other health professionals	15	26	<0.001
The institution (e.g., a hospital, clinic, or nursing home facility)	22	43	<0.001
Health professional involved			
Told respondent that an error had been made	31	30	0.19
Apologized to respondent or family member	34	33	0.14
Respondent or family member sued health professional	2	6	<0.001

*A total of 290 physicians and 507 members of the public reported an error in their own care or that of a family member.

spondents who reported experience with an error assigned "a lot" of responsibility to the physicians involved (Table 1). The public was significantly more likely than physicians to attribute the error to the institution involved. Malpractice lawsuits after an error were reported infrequently (by 2 percent of physicians and 6 percent of the public). However, 48 percent of physicians reported that they had been named in a malpractice lawsuit at some time in their career.

Twenty-nine percent of physicians reported having seen an error in the previous year in their capacity as physicians. Among these physicians, 60 percent believed that a similar error was very or somewhat likely to occur at the same institution during the next year.

Views of Medical Errors

Neither physicians nor the public named medical errors as one of the largest problems in health care today. The problems cited most frequently by physicians were the costs of malpractice insurance and lawsuits (cited by 29 percent of the respondents), the cost of health care (27 percent), and problems with insurance companies and health plans (22 percent). In the survey of the public, the issues cited most frequently were the cost of health care (cited by 38 percent of the respondents) and the cost of prescription drugs (31 percent). Only 5 percent of physicians and 6 percent of the public identified medical errors as one of the most serious problems.

Before being given the definition of the term "medical error," 68 percent of the respondents in the survey of the public reported that they did not know what the term meant. After being given the definition, approximately half the respondents thought these errors are made very often or somewhat often when people seek help from health professionals, as compared with only one fifth of physicians (Table 2).

The majority of both physicians and the public believed that 5000 or fewer deaths in hospitals each year are due to preventable medical errors — a much lower number than either the high or low IOM estimate. A majority of respondents in both surveys thought that one half or fewer of these deaths could have been prevented.

Causes of Medical Errors

Of the 11 items listed as possible causes of medical errors, only 2 were thought by at least half the physicians to be very important causes: understaffing of nurses in hospitals (53 percent) and overwork, stress, or fatigue on the part of health professionals (50 percent) (Table 3). In the survey of the public, at least half

TABLE 2. BELIEFS ABOUT THE FREQUENCY OF MEDICAL ERRORS AND PREVENTABLE DEATHS.*

QUESTION AND RESPONSE	PHYSICIANS (N=831)	PUBLIC (N=1207)	P VALUE
	percent		
How often are preventable medical errors made?			
Very often	1	10	<0.001
Somewhat often	19	39	<0.001
Not very often	59	37	<0.001
Not often at all	21	8	<0.001
No response	0	6	
How many Americans die in hospitals each year because of preventable medical errors?			
500	17	24	<0.001
5000	46	36	<0.001
50,000	25	20	0.002
100,000	9	7	0.12
≥500,000	1	4	<0.001
No response	1	9	
What proportion of these deaths could realistically have been prevented?			
All of them	8	11	0.04
Three quarters of them	27	29	0.48
Half of them	41	42	0.71
One quarter of them	21	13	<0.001
None of them	2	1	0.05
No response	1	3	

*Percentages may not always sum to 100 because of rounding.

the respondents considered seven of the causes very important. The top four causes considered to be very important were physicians' not having enough time with patients (72 percent); overwork, stress, or fatigue on the part of health professionals (70 percent); failure of health professionals to work together or communicate as a team (67 percent); and understaffing of nurses in hospitals (65 percent).

When asked whether mistakes made by health professionals or those made by health care institutions were a more important cause of medical errors, a majority of respondents in both groups chose mistakes made by health professionals as the more important cause (55 percent of physicians and 55 percent of the public). In addition, a majority of both groups thought that patients were very often or somewhat often at least partially responsible for errors made in their care.

Proposed Solutions

Of the 16 proposed solutions, a majority of physicians thought that 2 would be very effective at reducing the number of medical errors: requiring hospitals to develop systems for preventing medical errors (55 percent) and increasing the number of nurses in hospitals (51 percent) (Table 4). A majority of the respondents in the survey of the public rated eight items as very effective. The top four items were giving physicians more time to spend with their patients (78 percent), requiring hospitals to develop systems for preventing errors (74 percent), providing better training of health professionals (73 percent), and using only physicians trained in intensive care medicine on intensive care units (73 percent).

There were important areas of divergence in the views of the two groups. For instance, only 3 percent of physicians but 50 percent of the public viewed suspension of the licenses of health professionals as a very effective way to reduce medical errors ($P<0.001$) — a difference of 47 percentage points — and only 23 percent of physicians but 71 percent of the public viewed a requirement that hospitals report errors to a state agency as very effective ($P<0.001$) — a difference of 48 percentage points. Only 21 percent of physicians, but 62 percent of the public, thought that encouraging voluntary reporting of serious medical errors to a state agency would be very effective. Eighty-six percent of physicians believed that hospital reports of errors should be kept confidential, whereas 62 percent of the public believed that reports should be made public ($P<0.001$).

High-Volume Centers

Seventy-one percent of physicians thought that an error would be more likely at a hospital that performs a low volume of procedures than at a high-volume center. The public was divided on this issue; about half the respondents thought that an error would be more likely at a low-volume center (49 percent), and the other half thought either that an error would be more likely at a high-volume center (23 percent) or that volume would make no difference (26 percent) (Table 4). In neither group did a majority of respondents think that limiting certain high-risk procedures to high-volume centers would be a very effective way to reduce medical errors (Table 3).

Consequences for Health Professionals Who Make Errors

The attribution of responsibility for an error in the vignette did not appear to be influenced by whether or not the error was associated with harm to the patient. Most respondents in both groups said that the surgeon had "a lot" of responsibility; a smaller proportion held the hospital responsible (Table 5). Physicians were more likely than the public to hold the nurse responsible for the error, regardless of the outcome.

In general, the public was more likely than physicians to believe that the surgeon should be sued for malpractice and fined and that the surgeon's license should be suspended, as well as to support sanctions against the hospital. Support for various consequences for those involved in the medical error differed sub-

TABLE 3. CAUSES OF PREVENTABLE MEDICAL ERRORS.

RESPONSE	PHYSICIANS (N=831)	PUBLIC (N=1207)	P VALUE
	percent		
Very important causes			
Understaffing of nurses in hospitals	53	65	<0.001
Overwork, stress, or fatigue on the part of health professionals	50	70	<0.001
Failure of health professionals to work together or communicate as a team	39	67	<0.001
Influence of HMOs and other managed-care plans on treatment decisions*	39	48	<0.001
Complexity of medical care	38	62	<0.001
Insufficient time spent by doctors with patients	37	72	<0.001
Poor training of health professionals	28	54	<0.001
Poor handwriting by health professionals	21	48	<0.001
Poor supervision of health professionals	16	50	<0.001
Uncaring health professionals	15	47	<0.001
Lack of computerized medical records	13	35	<0.001
The more important reason for errors			
Mistakes made by individual health professionals	55	55	0.72
Mistakes made by institutions	43	38	0.009
No response	2	7	
Volume of procedures†			
An error is more likely at a high-volume hospital	4	23	<0.001
An error is more likely at a low-volume hospital	71	49	<0.001
Volume does not make a difference	24	26	0.23
No response	1	3	
Patients are at least partially responsible for errors made in their own care			
Very often	10	11	0.51
Somewhat often	48	48	0.89
Not very often	41	35	0.002
Never	1	5	<0.001
No response	0	1	

*HMOs denotes health maintenance organizations.

†Percentages for the public do not always sum to 100 because of rounding.

stantially according to the outcome of the vignette. If the patient was harmed, physicians were significantly more likely to support malpractice lawsuits against the surgeon, the nurse, and the hospital, and the public was substantially more likely to support lawsuits and suspension of the surgeon's license.

DISCUSSION

Our results have a number of implications for national efforts to reduce medical errors. First, major efforts to change hospital and medical practice are likely to face some important challenges. Even though significant percentages of practicing physicians and the public reported personal experience with medical errors that had serious consequences and despite the media's interest in the problem, medical errors are not viewed by either group as one of the most important problems in health care. The costs of malpractice insurance, lawsuits, and health care costs were considered more important. The public and physicians are concerned about individual cases of medical errors, and when the patient is seriously harmed, both groups want some action to be taken. However, both groups believe that the number of in-hospital deaths resulting from errors is much lower than that suggested by the IOM and also believe that a substantial proportion of these deaths are not preventable.

Second, physicians and the public differ in their beliefs about measures that would be very effective in reducing the incidence of errors. The public appears to believe that a range of proposals aimed at reducing medical errors would be very effective. However, the majority of practicing physicians view only two proposals as very effective: requiring hospitals to develop systems for preventing medical errors and increasing the number of nurses in hospitals.

In particular, although the physicians surveyed believe that high-volume medical centers have fewer medical errors — a view espoused by several authors[22-25] — only a minority believed that moving patients to high-volume centers would be a very effective way to reduce medical errors. This may be due to the belief that errors occur infrequently and that changing medical practice would therefore have a limited effect. Half

TABLE 4. POSSIBLE SOLUTIONS TO THE PROBLEM OF MEDICAL ERRORS.*

SOLUTION	PHYSICIANS (N=831)	PUBLIC (N=1207)	P VALUE
	percent		
Very effective			
Requiring hospitals to develop systems for preventing medical errors	55	74	<0.001
Increasing the number of nurses in hospitals	51	69	<0.001
Giving physicians more time to spend with patients	46	78	<0.001
Limiting certain high-risk procedures to hospitals that perform many of these procedures	40	45	0.03
Improving the training of health professionals	36	73	<0.001
Using only physicians trained in intensive care medicine on intensive care units	34	73	<0.001
Reducing the work hours of physicians in training to prevent fatigue	33	66	<0.001
Increasing the use of computers to order drugs and medical tests	23	45	<0.001
Requiring hospitals to report all serious medical errors to a state agency	23	71	<0.001
Encouraging hospitals to report serious medical errors voluntarily to a state agency	21	62	<0.001
Including a pharmacist on hospital rounds when physicians review the care of patients	20	40	<0.001
Increasing the use of computerized medical records	19	46	<0.001
Having hospitalized patients taken care of by hospital physicians rather than by their regular physicians	6	16	<0.001
Suspending the licenses of health professionals who make medical errors	3	50	<0.001
Increasing lawsuits for malpractice	1	23	<0.001
Having a government agency fine health professionals who make medical errors	2	40	<0.001
Physicians should be required to tell patients when errors are made in their care			
Yes	77	89	<0.001
No	22	9	
No response	1	3	
Hospital reports of serious medical errors			
Should be confidential (used only to learn how to prevent future mistakes)	86	34	<0.001
Should be released to the public	14	62	<0.001
No response	0	4	

*Percentages for the public do not always sum to 100 because of rounding.

the respondents in the survey of the public did not see an advantage of high-volume centers, suggesting a need for education of physicians and the public if a strategy based on the volume of procedures is pursued.

Our results point to a substantial difference between the views of physicians and those of the public on the reporting of medical errors to state agencies, a recommendation embraced by a number of national groups. The public sees reporting as a very effective way of reducing errors and wants these reports to be publicly available. Physicians are more skeptical about this proposal and would prefer that reports be kept confidential.

Finally, the results point to a gap between the views of the public and proposed approaches to preventing medical errors. One of the central statements in the IOM report is that errors should be viewed as due primarily to failures of institutional systems rather than failures of individuals. This is not a premise that the public embraces. The public believes that persons responsible for errors with serious consequences should be sued, fined, and subject to suspension of their professional licenses. Nor do physicians seem to believe that individual health professionals are blameless. A majority of physicians believe that individual health professionals are more likely to be responsible for preventable medical errors than are institutions. Moreover, although few physicians believe that an increase in malpractice suits would be effective in preventing individual errors, many believe that health professionals who make errors with serious consequences should be subject to lawsuits. The results of our surveys show

TABLE 5. RESPONSES TO THE VIGNETTE.*

RESPONSE	OUTCOME WITHOUT HARM			OUTCOME WITH HARM			P VALUE FOR DIFFERENCE IN OUTCOME	
	PHYSICIANS (N=401)	PUBLIC (N=603)	P VALUE	PHYSICIANS (N=427)	PUBLIC (N=604)	P VALUE	PHYSICIANS	PUBLIC
	percent			percent				
Party with "a lot" of responsibility for the error								
Surgeon	90	89	0.67	95	92	0.04	0.006	0.04
Nurse	81	52	<0.001	82	48	<0.001	0.86	0.19
Hospital	42	55	<0.001	48	57	0.01	0.09	0.64
Should be sued for malpractice								
Surgeon	4	30	<0.001	55	69	<0.001	<0.001	<0.001
Nurse	3	12	<0.001	44	21	<0.001	<0.001	<0.001
Hospital	2	22	<0.001	33	44	<0.001	<0.001	<0.001
Should be fined by a government agency								
Surgeon	5	51	0.001	21	65	<0.001	<0.001	<0.001
Nurse	6	26	0.001	18	29	<0.001	<0.001	0.27
Hospital	9	39	0.001	21	50	<0.001	<0.001	<0.001
Should have license suspended								
Surgeon	0	23	<0.001	8	50	<0.001	<0.001	<0.001
Nurse	1	11	<0.001	8	25	<0.001	<0.001	<0.001
Hospital should lose its accreditation	1	11	<0.001	1	15	<0.001	0.73	0.03
Should be required to report the error to the patient or family								
Surgeon	85	95	<0.001	90	95	0.003	0.05	0.60
Nurse	74	67	0.02	70	57	<0.001	0.12	<0.001
Hospital	60	78	<0.001	71	84	<0.001	<0.001	0.005
Should be required to undergo training in the prevention of the type of error that was made								
Surgeon	66	80	<0.001	78	80	0.53	<0.001	0.89
Nurse	71	67	0.17	81	72	<0.001	<0.001	0.05
The hospital should be required to develop systems for preventing similar errors	74	79	0.09	84	84	0.86	<0.001	0.01

*The following vignette was used: "A 67-year-old man goes to the hospital for surgery. He has an allergy to antibiotic drugs, which is noted on his medical record. The surgeon does not notice the information about the allergy and orders an antibiotic to be given at the end of the surgery. A hospital nurse gives the patient the antibiotic." The respondents who received the version that did not involve harm were told, "The patient wakes up with a rash all over his body. The mistake is noticed, the antibiotic is stopped, and the patient fully recovers." The respondents who received the version that did involve harm were told, "The patient wakes up with a rash all over his body and is gasping for air. The mistake is noticed, and the antibiotic is stopped, but the patient stops breathing. Despite every effort, the patient dies."

that the public and, to a lesser extent, physicians hold individual health professionals personally responsible for errors. Although they do support a requirement that hospitals develop systems to prevent future errors, the public is unlikely to support the substitution of a system in which individuals are not subject to sanctions.

The momentum for instituting changes to reduce medical errors is sustained primarily by a range of groups and by the media's interest in the problem — not by practicing physicians or the public. Our findings highlight the issues and potential barriers that national groups such as the IOM, the Leapfrog Group (a consortium of purchasers of health insurance), and the American Medical Association must address if they are to succeed in their efforts to reduce medical errors. Perhaps the most critical issue will be to provide skeptical physicians with scientific proof that the proposed strategies will, in fact, reduce preventable medical errors and the harm they cause.

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PHYSICIANS PRACTICING IN ALASKA

PREPARED FOR REPRESENTATIVE LES GARA

BY PATRICIA YOUNG, MANAGER

You wished to know the number of physicians practicing in Alaska as compared to the population over the last several years. You particularly wished to know if the per capita number of physicians is in a declining trend.

The attached table shows the number of active, state-licensed physicians by year since 1985, as well as the population and the number of practicing physicians per 1,000 residents for each year since that time.[1] As you will see, by this measure, the number of physicians per 1,000 residents has, overall, increased steadily.

We also include a chart prepared by the State Medical Board showing the numbers of physicians as well as other primary health providers since 1985.

I hope you find this information to be useful. Please do not hesitate to contact us if you have questions or need additional information.

[1] These numbers reflect active, state-licensed medical doctors and doctors of osteopathy only. Doctors of podiatric medicine are not included because the numbers of active and inactive practitioners are not separated. We do not include federal physicians; because they are not licensed by the State Medical Board, their annul numbers are far less readily available.

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Alaska Legislature
Legislative Research Services
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State Capitol
Juneau, AK 99801

State Licensed Physicians and Alaska Population, 1985-2003

Fiscal Year	Population	State Licensed Physicians	State-Licensed Physicians per 1,000 Residents
1985	543,900	815	1.50
1986	550,700	934	1.70
1987	541,300	1,027	1.90
1988	535,000	1,089	2.04
1989	538,900	925	1.72
1990	553,171	1,038	1.88
1991	569,054	1,004	1.76
1992	586,722	1,152	1.96
1993	596,906	1,183	1.98
1994	600,622	1,417	2.36
1995	601,581	1,419	2.36
1996	605,212	1,593	2.63
1997	609,655	1,603	2.63
1998	617,082	1,826	2.96
1999	622,000	1,810	2.91
2000	627,576	2,034	3.24
2001	632,674	1,850	2.92
2002	641,482	2,080	3.24
2003	648,818	2,099	3.24

Notes: Numbers of physicians reflect active state-licensed medical doctors and doctors of osteopathy only; doctors of podiatric medicine are not included because their numbers include both active and inactive practitioners; federal physicians are not included because they are not licensed by the State Medical Board.

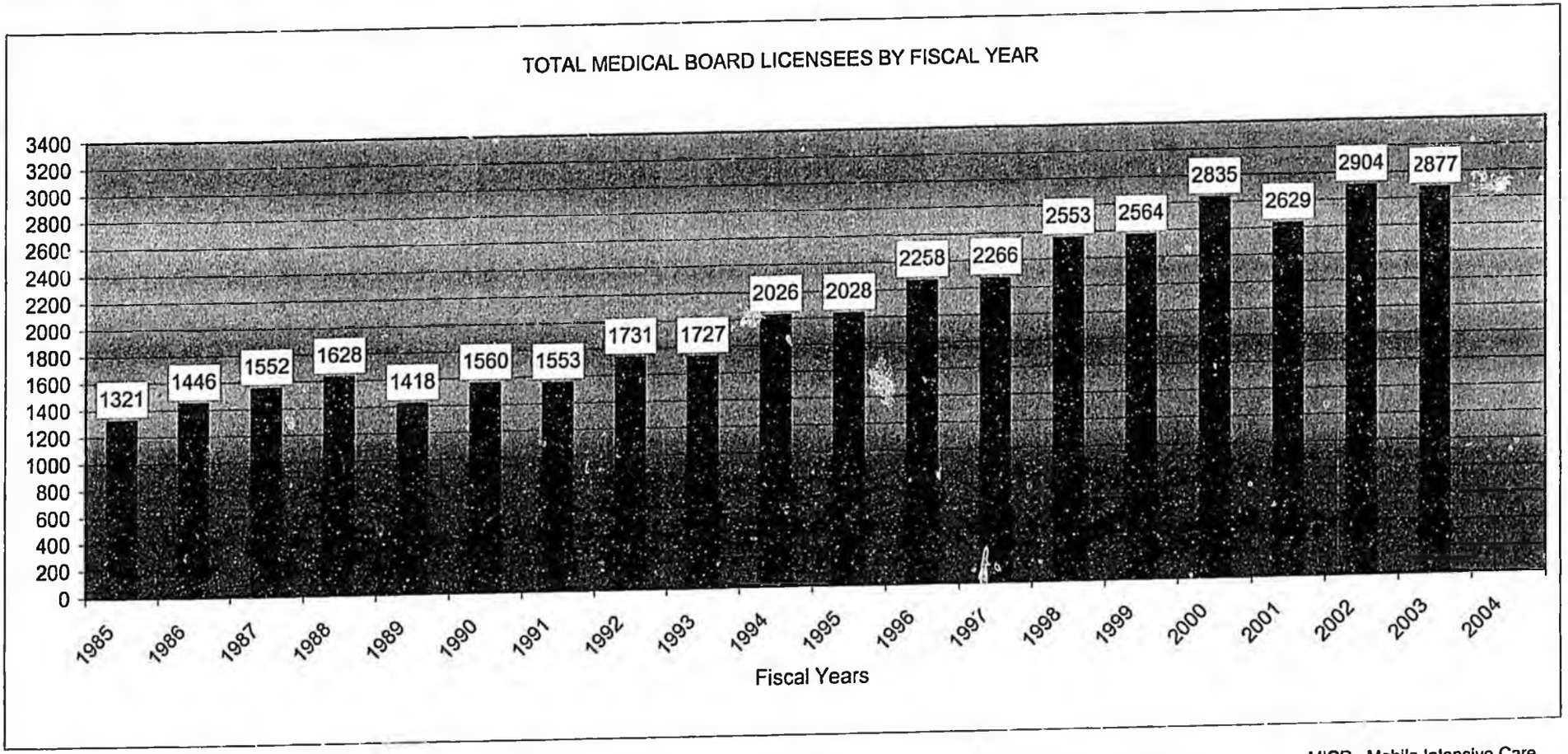
According to the American Medical Association, as reported in "Federal Physicians in 2001," Health Care State Rankings, 2003 (Morgan Quitno Press, 2003, p. 430), in 2001, Alaska had 147 federal physicians.

Population figures for 2003 are provisional.

Sources: Alaska State Medical Board, and Alaska Department of Labor and Workforce Development.

TOTAL PHYSICIANS, PHYSICIAN ASSISTANTS, AND PARAMEDICS BY FISCAL YEAR

	FY 85	FY 86	FY 87	FY 88	FY 89	FY 90	FY 91	FY 92	FY 93	FY 94	FY 95	FY 96	FY 97	FY 98	FY 99	FY 00	FY 01	FY 02	FY 03	FY04
MD/DO Active	815	934	1027	1089	925	1038	1004	1152	1183	1417	1419	1593	1603	1826	1810	2034	1850	2080	2099	
MD/DO Inactive	317	305	279	322	255	254	273	263	243	243	262	262	277	266	300	289	285	268	249	
DPM-Act/Inact	0	11	11	0	0	0	9	11	12	15	13	14	14	15	15	16	16	17	18	
PA-C-Act/Inact	111	111	134	126	138	157	159	186	177	216	200	231	221	255	244	266	245	284	266	
MICP-Active	78	85	101	91	100	111	108	119	112	135	134	158	151	191	195	230	233	255	245	
TOTAL	**1321**	**1446**	**1552**	**1628**	**1418**	**1560**	**1553**	**1731**	**1727**	**2026**	**2028**	**2258**	**2266**	**2553**	**2564**	**2835**	**2629**	**2904**	**2877**	
% Variance from Previous Year	–	+9.4	+7.3	+4.8	-12.9	+10	- .05	+11.4	- .02	+17.3	–	+11.3	.03	+12.6	+.04	+11	-7.8	+10.4	-.09	



MD - Medical Doctor (allopathic)

DO - Doctor of Osteopathy

DPM - Doctor of Podiatric Medicine

PA-C - Physician Assistant-Certified

MICP - Mobile Intensive Care Paramedic

Source: Leslie Gallant, Alaska State Medical Board

Medical Malpractice Caps

The Impact of Non-Economic Damage Caps on Physician Premiums, Claims Payout Levels, and Availability of Coverage

by

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Table of Contents

Medical Malpractice Caps

The Impact of Non-Economic Damage Caps on Physician Premiums, Claims Payout Levels, and Availability of Coverage

Executive Summary

Soaring premiums on medical malpractice insurance ("med mal") are a national crisis, invading the practice of medicine, threatening the availability of care, and prompting widespread public outcry. Physicians and the insurance industry place the blame on out-of-control jury awards, and, in response, 19 states have implemented caps on non-economic damages—a key measure now included in various congressional proposals. However, the actual experience of the states with caps does not support these proposals. It shows that:

Caps did reduce the burden on insurers...

- In states with caps, the median payout between 1991 and 2002 was 15.7% lower than the median in states without caps, despite the fact that many states did not impose the caps until late in the 12-year period.
- Moreover, in states with caps, the payouts increased by 83.3% from 1991 to 2002, while the rate of increase in states without caps was 127.9%.

But most insurers continued to increase premiums at a rapid pace, regardless of caps...

- In states with caps, the median annual premium went up by 48.2%, but, surprisingly, in states *without* caps, the median annual premium increased at a *slower* clip—by 35.9%.
- Among the states with caps, only 10.5% experienced flat or declining med mal premiums. In contrast, among the states *without* caps, the record was actually *better*: 18.7% experienced flat or declining premiums.

These counter-intuitive findings can lead to only one conclusion: There are other, far more important factors driving the rise in med mal premiums than caps or med mal payouts. These include:

- The medical inflation rate. In the 12-year period through 2002, medical costs rose 75%.

- The insurance business cycle. The property and casualty industry as a whole suffered an unusually long 12-year "soft" period in the insurance business cycle through 1999, resulting in loose underwriting practices—not enough money in premiums collected to cover anticipated claims. At the end of the cycle, in an attempt to catch up, insurers began to tighten underwriting standards and raise premium rates.

- The need to shore up reserves. Med mal insurers have been consistently under-reserving since 1997—to the tune of $4.6 billion through December 31, 2001. The only way to shore up reserves is to increase premiums.

- A decline in investment income. With falling stock prices and declining interest rates, investment income for the entire property/casualty industry fell 23% in 2001 compared to 2000, and then *another* 2.5% in 2002. Moreover, investment income is particularly critical for lines of business like med mal where the duration of claims payouts typically spans several years.

- Financial safety. Based on the Weiss Safety Ratings, we find that 34.4% of the nation's med mal insurers are vulnerable to financial difficulties (those with a rating of D+ or lower), as compared to 23.9% of the property and casualty industry as a whole. In order to restore their financial health, many med mal insurers will remain under pressure to increase premiums despite new laws to cap payouts.

- Supply and demand. The number of med mal carriers increased until 1997, but has since fallen from 274 in that year to 247 in 2002. Moreover, in certain regions and medical specialties, there is evidence that some med mal insurers have pulled out or discontinued coverage.

Recommendations:

Legislators should put proposals involving non-economic damage caps on hold until convincing evidence can be produced to demonstrate a true benefit to doctors in the form of reduced med mal costs. *Regulators* must review and revise their parameters for approving rate increases. *Insurance companies* must never again allow marketing to divert or pervert prudent actuarial analysis and planning. The *medical profession* must assume more responsibility for policing itself, while states must be more pro-active in reviewing the licenses of individual practitioners. And *consumers* must not relinquish their right to sue for non-economic damages until the medical profession and/or state and federal governments provide more adequate supervision and regulation of doctors, hospitals, and other health care providers.

Introduction

In the last few years, soaring premiums on medical malpractice insurance ("med mal") have emerged as a national crisis, invading the practice of medicine, threatening the availability of care, and prompting widespread public outcry.

Many doctors, particularly in high-risk specialties, have received renewal notices announcing premium increases of 100% or even 200% over the previous year. Others have simply been dropped by their insurance carriers, forcing them to shop for new med mal coverage, practice without any coverage at all, or stop practicing medicine altogether—all painful alternatives.

The insurance industry places the blame on out-of-control jury awards. In response, legislators in many states, accepting this argument at face value, have implemented tort reform to restrict awards in their states. Their primary vehicle: *Non-economic damage caps,* which limit the awards to an injured patient for intangible injuries, such as pain and suffering. Since 1975, 19 states have implemented these caps[1] at various levels ranging from $250,000 to $1 million, as follows:

State	Cap ($)	Year Adopted
Alaska	500,000	1997[2]
California	250,000	1975
Colorado	250,000	1998
Hawaii	375,000	1976
Idaho	682,000	1990*
Indiana	1,000,000	1990
Kansas	250,000	1994
Louisiana	500,000	1975
Maryland	805,000	1986*
Massachusetts	500,000	1997
Michigan	624,000	1993*
Missouri	547,000	1988*
Montana	250,000	1997
New Mexico	600,000	1996
North Dakota	500,000	1996
Utah	250,000	1996
Virginia	1,000,000	1992
West Virginia	1,000,000	1986
Wisconsin	350,000	1995*[3]

*Caps are adjusted annually for inflation.

[1] The implementation of caps on non-economic damages has no impact on jury awards for actual damages such as medical expenses and loss of income.

[2] Applies to incidents occurring before August 1997. After August 1997: the cap is the greater of $400,000 or life expectancy times $8,000 except in the case of severe disfigurement or physical impairment in which the cap is the greater of $1 million or life expectancy times $25,000.

[3] Applies to damages from all health care providers except in wrongful death cases. Damages in wrongful death are limited to $500,000 for the death of a minor and $350,000 for the death of an adult.

Now, in an attempt to cope with the emerging med mal crisis, the push to impose caps has reached the federal level, with a number of legislative proposals to institute reforms, usually including, as the most salient feature, a $250,000 nationwide cap.

This white paper is not driven by a political ideology or industry-driven self-interest. It is, rather, an objective, data-driven analysis of:

- the real relationship between caps and med mal premiums (Part 1)
- other forces behind rising premium rates (Part 2)
- lessons to be learned from the crisis along with effective long-term solutions (Part 3).

Part 1. The Real Relationship between Caps and Med Mal Premiums

On the surface, the theory behind caps on non-economic damage awards seems logical: caps would limit the payouts by insurers, and the lower payouts, in turn, would naturally enable the insurers to reduce med mal premiums. As we shall demonstrate below, however, in the real world of the med mal insurance business, only the first half of this theory is working.

Caps do reduce the burden on insurers...

Using data provided by the National Practitioner Data Bank, we compared the median payouts in the 19 states with caps to those in the 32 states without caps[4] for the period between 1991 and 2002, with the following results:

- **Payouts reduced.** In states without caps, the median payout for the entire 12-year period was $116,297, ranging from $75,000 on the low end to $220,000 on the high end. In states with caps, the median was 15.7% lower, or $98,079, ranging from $50,000 to $190,000.[5] Since caps in many states were not imposed until late in the 12-year period, this represents a significant reduction.

- **Growth in payouts slowed substantially.** The median payout in the 32 states without caps increased by 127.9%, from $65,831 in 1991 to $150,000 in 2002. In contrast, payouts in the 19 states with caps increased at a far slower pace—by 83.3%, from $60,000 in 1991 to $110,000 in 2002.

In short, it's clear that caps do accomplish their intended purpose of lowering the average amount insurance companies must pay out to satisfy med mal claims.

But insurers continue to increase premiums at a rapid pace, regardless of caps.

Using 1991 to 2002 data published by the Medical Liability Monitor, we examined the median med mal premiums paid by doctors in three high-risk specialties—internal medicine, general surgery, and obstetrics/gynecology. The results:

1. **States with caps had sharper increases in median annual premiums.** Since the insurers in the states with caps reaped the benefit of lower med mal payouts, one would expect that they'd reduce the premiums they charged doctors. At the very minimum, they should have been able to slow down the rate of premium increases. Surprisingly, the data show they did precisely the opposite:

    - In the 19 states with caps, the median annual premium increased by 48.2%, from $20,414 in 1991 to $30,246 in 2002.

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[4] For the purposes of this analysis, the District of Columbia is being referred to as a "state" since it effectively operates as such with regard to insurance regulation.

[5] Adjusted for inflation in order to evaluate figures spanning multiple years.

- In the 32 states *without* caps, the median annual premium actually increased at a *slower* pace—by 35.9%, from $22,118 in 1991 to $30,056 in 2002.

Thus, on average, *doctors in states with caps actually suffered a significantly larger increase than doctors in states without caps.*

2. **A smaller proportion of states with caps were able to contain premium increases.** In some states, the median annual premiums remained flat or even declined at various times during the period. Was *this* related to the imposition of caps? In the overwhelming majority of states, the answer is clearly "no." Indeed...

   - Among the 19 with caps, only two states, or 10.5%, experienced flat or declining med mal premiums following the imposition of caps.

   - Meanwhile, among the 32 without caps, the record was actually much better: Six states, or 18.7%, experienced flat or declining premiums.

3. **Premiums in states with caps are more likely to exceed national median.** Focusing on the most recent data, we find that:

   - In 47.4% of the states with caps (9 out of 19), 2002 median premiums were below the national median premium of $30,093.

   - Meanwhile, in 50% of the states without caps (16 out of 32), 2002 median premiums were *below* the national median.

In short, the results clearly invalidate the expectations of cap proponents. To review the surprising facts:

- Insurers in states with caps raised their premiums at a significantly faster pace than those in states without caps.

- Even with the imposition of caps, insurers in nearly nine out of ten states continued to raise rates, while insurers in states without caps were actually *more* likely to hold or cut their premium rates.

- In states with caps, insurers are more likely to charge med mal premiums exceeding the national median than those in states without caps.

These counter-intuitive findings can lead to only one conclusion: There are other, far more important factors driving the rise in med mal premiums than caps or med mal payouts, the subject of the next section.

Part 2. Other Factors Driving Up Med Mal Premiums

We have identified six factors driving up premiums, each of which may be exerting a greater impact on premiums than the presence or absence of caps. These are (1) medical cost inflation, (2) the cyclical nature of the insurance market, (3) the need to shore up reserves for policies in force, (4) a decline in investment income, (5) overall financial safety considerations, and (6) the supply and demand of coverage. We examine each of these factors below.

1. Medical Cost Inflation

The medical inflation rate in the 12-year period was 75%[6] (i.e., $1 of medical expenses in 1991 cost $1.75 in 2002). However, throughout the country, insurers had a general tendency to let their premium increases lag behind the pace of medical inflation. This was most likely due to the extended soft market experienced by the entire property and casualty insurance industry in the 1990s, explained below.

2. The Cyclical Nature of the Insurance Market

The market for property/casualty insurance, including med mal, is historically and fundamentally cyclical, with periods of rising premium rates followed by periods of steady or declining premiums. In the declining portion of the cycle—"a soft market"—insurers relax their underwriting standards and underprice their products in order to retain or gain market share.

The most recent soft market lasted longer than usual—12 years, from 1987 to 1999—probably because of the raging bull market in stocks. Insurers made so much money in their investments they were able to aggressively underprice their policies, deliberately lose money in their underwriting, and still turn a profit overall. As a result, losses in their core operations, more than offset by surging gains from the stock market boom, were largely overlooked by the industry and regulators alike.

All that changed when the stock market boom turned to bust. Property and casualty insurers had to confront the ramifications of their loose underwriting practices: not enough money in premiums collected to cover anticipated claims. That's when they began to seriously tighten underwriting standards and raise premium rates.

3. The Need to Shore Up Reserves for Policies in Force

When insurers write a new policy, they look at past claims experience, make some actuarial assumptions, and place a portion of that policy's premium into a reserve to cover expected future claims. A prudent insurer will make conservative assumptions and err on the side of having more in reserve than it ultimately needs to pay claims. At the end of each year, the insurer then evaluates its reserves for each block of business and determines if a change is warranted to either add or subtract reserves.

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[6] Medical inflation rate: 1991: 8.7%, 1992: 7.4%, 1993: 5.9%, 1994: 4.8%, 1995: 4.5%, 1996: 3.5%, 1997: 2.8%, 1998: 3.2%, 1999: 3.5%, 2000: 4.1%, 2001: 4.6%, 2002: 4.7%.

Data reported to the National Association of Insurance Commissioners (NAIC) show that med mal insurers have been consistently under-reserving since 1997—to the tune of $4.6 billion through December 31, 2001. The under-reserving came to a head in 1999, at the tail end of the soft market. That's when loose underwriting practices caught up with the insurers, as claims rose to a higher level than expected. Thus, even before the bull market ended in the stock market, insurers were coming under increasing pressure to boost their reserves to make up for past shortfalls.

There's only one place these funds could come from—the company's capital; and there was only one way the company could maintain or build its capital—by making more profits. Thus, premium increases were inevitable.

4. A decline in investment income

Until 2000, most of the additional profits insurers needed could be covered by rising investment income and gains from the booming stock market. But during the three-year bear market from 2000 to 2002, as large stock market gains turned to even larger stock market losses, insurers were confronted with double trouble:

- After just one year of premium increases, they still had barely begun to restore their reserves.

- Now, aggravating their difficulties, they also needed to compensate for stock market losses. With falling stock prices and declining interest rates, investment income[7] for the entire property/casualty industry fell 23% in 2001 compared to 2000, and then *another* 2.5% in 2002; and we must assume that med mal insurers suffered a similar decline. Indeed, investment income is particularly critical for lines of business like med mal where the duration of claims payouts typically span several years.

Thus, it was the combination of two powerful forces—under-reserving throughout most of the 1990s *plus* the rapid fall in investment income in the 2000s—that largely drove the unusually rapid premium increases, not only in med mal, but in many other property and casualty lines as well.

5. Financial Safety

If insurers do not replace capital that has been used to shore up reserves, the financial strength of the company deteriorates, ultimately leading to the possibility of financial failure.

The Weiss Safety Ratings measure an insurer's overall financial strength based on evaluations of its capitalization, reserve adequacy, profitability, liquidity, and stability. Among the 2,851 property and casualty insurers reporting to the NAIC, 247 companies wrote at least some med mal policies in 2002, with 90 of these deriving at least 50% of their total premiums from the med mal sector.

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[7] Investment income is defined as capital gains plus interest income.

Within this group of 90, which we define as "med mal insurers," there were a higher-than-average number of vulnerable companies, as compared to the property and casualty industry as a whole (Table 1).

Table 1. Safety of Insurers: Med Mal vs. All Property and Casualty Insurers

Weiss Safety Rating Category	2003 All P&C Insurers	2003 Med Mal Insurers
Secure	76.1%	65.5%
Vulnerable	23.9%	34.4%

"Secure" includes companies rated A (Excellent), B (Good), and C (Fair).
"Vulnerable" includes those rated D (Weak) and E (Very Weak)

What progress have med mal insurers made in restoring their financial health by raising premiums? So far, none: Despite higher premiums since 1999, there has been no improvement in the financial safety of the med mal insurers. Quite to the contrary, the proportion of insurers in the "vulnerable" category has increased since 1999 (Table 2).

Table 2. Safety of Med Mal Insurers: 2003 vs. 1999

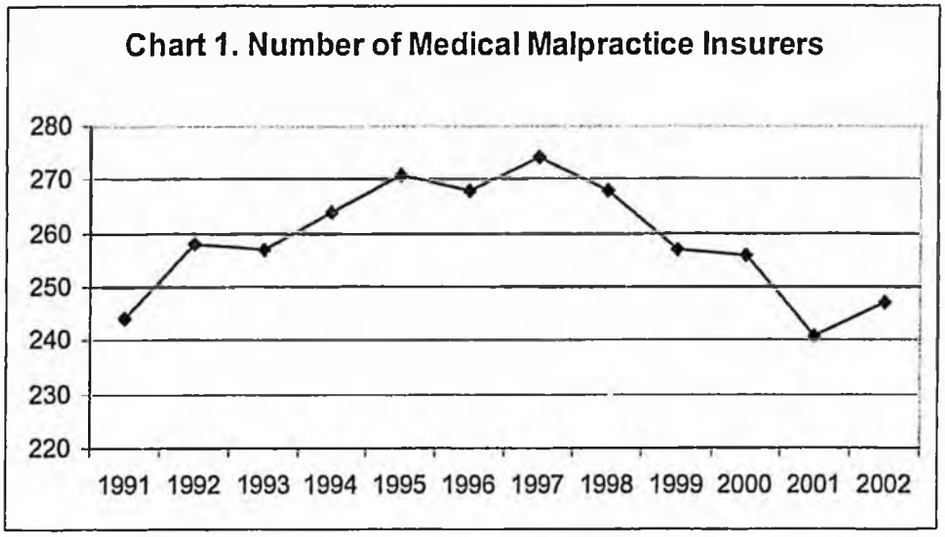
Weiss Safety Rating Category	2003 Med Mal Insurers	1999 Med Mal Insurers
Secure	65.5%	69.0%
Vulnerable	34.4%	31.0%

Thus, in order to restore their financial health, *many med mal insurers will remain under pressure to continue to increase premiums despite any new laws that are enacted to cap individual payouts.*

6. The Supply and Demand of Coverage

Press reports have highlighted the plight of physicians around the country who are closing up shop because their med mal insurer is pulling out of the local market.

To help determine if this is an industry-wide problem, for each year between 1991 and 2002, we counted the number of insurers that are writing new med mal policies and/or renewing existing policies (Chart 1).



The number of carriers providing med mal coverage nationwide increased from 244 in 1991 to a peak of 274 in 1997. Since 1997, however, the number of carriers declined steadily to a low of 241 in 2001, recovering slightly to 247 in 2002.

Compared to 1991, therefore, there has actually been a modest *increase* in the number of med mal carriers—from 244 to 247.

However, doctors are currently feeling the pressures of diminished supply reflected in the declining trend since 1997. Moreover, in certain regions and in certain medical specialties, there is abundant anecdotal evidence that certain med mal insurers have pulled out or discontinued coverage.

Part 3. Conclusions and Recommendations

There is no doubt that the implementation of non-economic damage caps has resulted in lower claim payouts for insurers. For caps to be considered successful, however, the lower payouts would need to translate into lower med mal premiums for medical professionals. Unfortunately, that has not been the case due to the continuing presence of other, far more significant factors driving premium rates higher.

Indeed, the 1991 to 2002 data indicate that the presence of caps may be *inversely correlated* to med mal premium levels. We have no data to pinpoint the reasons for this perverse result and therefore can only speculate as to what they may be. Some possibilities include:

- Legislatures in states with a preponderance of unprofitable med mal insurers may have been among those that were most pressured by those insurers and their lobbyists to impose caps. Meanwhile, states that have not imposed caps so far may be those in which med mal insurers were relatively less desperate to begin with. Insurers in states with caps may have *already* been on the path toward faster rate increases even before the caps were legislated, and the changes in the legislation may have merely been a symptom of—not an impediment to—this trend.

- Once caps were imposed, regulators in those states may have been somewhat more liberal in allowing rate increases, making the false assumption that caps alone would sooner or later help to correct the imbalances in the marketplace.

Furthermore, med mal insurers have also had to deal with the added burden of high medical inflation, which directly impacts their claims experience. By the end of the soft market in 2000, these insurers found themselves in a position where claims costs had increased, but premium income had not even kept pace with inflation.

All of these forces led to an inevitable increase in the med mal premiums insurers charge to doctors and other medical professionals. But despite the increase in revenue, the med mal insurers as an industry have continued to weaken financially and remain weaker than the overall property/casualty insurance industry.

In summary, we believe the broad market forces prevailing in the property/casualty industry have driven—and continue to drive—med mal premiums up, evidently overwhelming any reduction in jury awards.

Thus, by focusing on caps as a solution...

- The insurance companies and their supporters are diverting the public's attention away from long years of mismanagement by an industry that continually allowed actuarial prudence to take a back seat to marketing strategy.

- The insurers, insurance regulators and insurance legislators are avoiding a much-needed post-mortem on what really went wrong in the property and casualty industry

in general and in the med mal sector in particular. Was it prudent to rely so heavily on investment income while underwriting income stayed chronically in the red? Did industry decision makers get caught up in the stock market euphoria like nearly everyone else?

- Worst of all, many companies and legislators are using the insurance crisis opportunistically to push tort reform. However, tort reform, to be productive, merits more pondered and balanced debate based on its own merits, independent of the insurance crisis.

We recommend the following steps:

First, *legislators* must immediately put on hold all proposals involving non-economic damage caps until convincing evidence can be produced to demonstrate a true benefit to doctors in the form of reduced med mal costs. Right now, consumers are being asked to sacrifice not only large damage claims, but also critical leverage to help regulate the medical profession—all with the stated goal that it will end the med mal crisis for doctors. However, the data indicate that, similar state legislation has merely produced the worst of both worlds: The sacrifice by consumers *plus* a continuing—and even worsening—crisis for doctors. Neither party derived any benefit whatsoever from the caps.

Second, *regulators* must review and revise their parameters for approving rate increases. The big lesson to be learned from the past decade is that it's dangerous to count on volatile investments—especially common stocks—to compensate for poor operations.

For many years, we have warned that rather than evaluating the property and casualty business based on total profits (including investment income), the focus should be on underwriting profits and losses, independent of investment income.[8] Had our warnings been heeded, premium rate increases may have risen gradually over time, rather than jumping suddenly during an already-painful bear market.

Third, *insurance companies* must never again allow marketing to divert or pervert prudent actuarial analysis and planning. Consumers and medical professionals can accept rate increases provided they are spread out evenly over time, and provided they are given good value for their premium dollars in terms of claims paying ability and stability. They cannot accept rate increases that are designed to cover up, or compensate for, serious mismanagement.

Fourth, *the medical profession* must assume more responsibility for policing itself, while states must be more pro-active in reviewing the licenses of individual practitioners who have a significantly higher-than-average number of claims against them in their specialty, in proportion to their level of activity. These individuals

[8] "Property & Casualty Insurers Cashing in on Wall Street Windfalls to Offset Underwriting Losses," February 28, 1997. "Property and Casualty Insurers Suffer 40% Decline in Net Income in 1994," April 18, 1995.

greatly increase the risk associated with their specialties, pushing med mal premiums up for all doctors in that sector. States must also make major strides to share data on high-risk doctors. At the very minimum, they must cease licensing doctors who have lost their licenses in other states, often due to high-cost medical mistakes.

Fifth, *consumers* must not relinquish their right to sue for non-economic damages until the medical profession and/or state and federal governments provide more adequate supervision and regulation of doctors, hospitals, and other health care providers.

The imposition of caps will not make a significant dent in the problem, and may even have adverse impacts. It is no substitute for longer-term, fundamental solutions that address the actual factors behind the med mal crisis.

Appendix 1

States with Caps:
Median Medical Malpractice Payouts/Premiums 1991 - 2002

State	Year Imposed	Amount of Cap ($000)	1991 Median Payout ($)	2002 Median Payout ($)	% Change 1991 to 2002	1991 Median Premium ($)	2002 Median Premium ($)	% Change 1991 to 2002
Alaska	1997	500	125,000	165,000	32.0	N/A	27,940	N/A
California	1975	250	31,700	67,500	112.9	20,354	30,430	49.5
Colorado	1998	250	25,000	100,000	300.0	22,678	33,651	48.4
Hawaii	1976	375	30,000	250,000	733.3	23,334	25,756	10.4
Idaho	1990	682	22,000	100,000	354.5	N/A	14,199	N/A
Indiana	1990	1,000	35,000	50,000	42.9	N/A	22,886	N/A
Kansas	1994	250	75,000	103,765	38.4	14,669	23,335	59.1
Louisiana	1975	500	65,000	100,000	53.8	20,291	37,280	83.7
Maryland	1986	605	75,000	180,000	140.0	24,193	34,771	43.7
Massachusetts	1997	500	100,000	250,000	150.0	N/A	30,246	N/A
Michigan	1993	624	60,000	77,000	28.3	65,946	68,225	3.5
Missouri	1988	547	80,000	162,500	103.1	25,999	38,759	49.1
Montana	1997	250	30,000	100,000	233.3	18,697	27,011	44.5
New Mexico	1996	600	100,000	110,000	10.0	N/A	67,161	N/A
North Dakota	1996	500	57,500	75,000	30.4	N/A	16,238	N/A
Utah	1996	250	20,000	115,000	475.0	20,474	37,290	82.1
Virginia	1992	1,000	50,000	200,000	300.0	16,497	21,343	29.4
West Virginia	1986	1,000	100,000	140,465	40.5	N/A	56,989	N/A
Wisconsin	1995	350	90,000	256,357	184.8	18,111	17,213	-5.0
Total			60,000	110,000	83.3	20,414	30,246	48.2

Source: Compiled and analyzed by Weiss Ratings, Inc. from data supplied by Medical Liability Monitor and the National Practitioners Data Bank

Appendix 2

States without Caps:
Median Medical Malpractice Payouts/Premiums 1991 - 2002

State	1991 Median Payout ($)	2002 Median Payout ($)	% Change 1991 to 2002	1991 Median Premium ($)	2002 Median Premium ($)	% Change 1991 to 2002
Alabama	75,000	200,000	166.7	25,629	23,490	-8.3
Arizona	66,875	169,240	153.1	37,601	38,571	2.6
Arkansas	72,495	125,000	72.4	10,422	16,384	57.2
Connecticut	66,663	250,000	275.0	29,198	40,146	37.5
Delaware	73,539	150,000	104.0	N/A	24,731	N/A
District of Columbia	172,000	162,500	-5.5	28,085	40,871	45.5
Florida	95,000	162,500	71.1	43,600	95,474	119.0
Georgia	75,000	175,000	133.3	27,998	30,093	7.5
Illinois	115,000	320,000	178.3	39,260	49,948	27.2
Iowa	41,250	102,500	148.5	21,140	18,607	-12.0
Kentucky	48,258	49,000	1.5	23,666	44,834	89.4
Maine	75,000	250,000	233.3	22,118	18,583	-16.0
Minnesota	45,000	125,000	177.8	8,117	10,142	25.0
Mississippi	45,000	131,500	192.2	19,726	30,871	56.5
Nebraska	39,000	131,250	275.0	N/A	14,710	N/A
Nevada	32,500	175,000	438.5	24,988	59,776	139.2
New Hampshire	50,000	250,000	400.0	N/A	27,157	N/A
New Jersey	75,000	210,000	180.0	20,162	38,307	90.0
New York	75,000	200,000	166.7	48,026	50,970	6.1
North Carolina	72,000	195,000	170.8	11,294	31,687	180.6
Ohio	24,667	137,500	457.4	31,450	52,764	67.8
Oklahoma	50,000	97,000	94.0	9,137	12,766	39.7
Oregon	65,000	95,000	46.2	17,268	26,711	54.7
Pennsylvania	100,000	200,000	100.0	11,433	71,260	523.3
Rhode Island	62,500	125,000	100.0	N/A	27,922	N/A
South Carolina	59,475	100,000	68.1	12,984	21,337	64.3
South Dakota	25,000	150,000	500.0	9,618	13,853	44.0
Tennessee	58,750	110,000	87.2	15,601	30,018	92.4
Texas	70,347	150,000	113.2	27,945	55,951	100.2
Vermont	42,500	40,865	-3.8	N/A	15,690	N/A
Washington	40,000	150,000	275.0	18,158	23,100	27.2
Wyoming	80,000	125,000	56.3	22,758	39,829	75.0
Total	65,831	150,000	127.9	22,118	30,056	35.9

Source: Compiled and analyzed by Weiss Ratings, Inc. from data supplied by Medical Liability Monitor and the National Practitioners Data Bank

Appendix 3

Weakest Medical Malpractice Insurers

Company	2002 Total Med Mal Premium ($000)	2002 Total Premium ($000)	Weiss Safety Rating
Academic Health Professionals Insurance	16,484	16,484	E
American Association of Orthodontist RRG	4,505	4,506	D
American Excess Insurance Exchange RRG	33,682	39,747	E
American Physicians Assurance	170,440	230,224	D
American Physicians Insurance Exchange	34,887	34,887	D
Campmed Casualty & Indemnity of MD	3,750	7,237	E+
Commonwealth Medical Liability Insurance	29,648	29,893	D+
Delaware Professional Insurance	732	732	E+
Eastern Dentists Insurance RRG	6,961	7,314	D
Franklin Casualty Insurance RRG	19,377	19,377	D-
Hanys Insurance	74,529	76,260	D+
Hospital Casualty	22,637	26,112	E
Hospital Underwriting Group	22,620	22,776	E
Lion Insurance	51	86	D+
MCIC Vermont RRG	155,021	162,325	D
MedAmerica Mutual RRG	7,838	7,838	D+
National Guardian RRG	7,422	7,422	E
New England Medical Center of VT	1,166	1,166	D-
Northwest Physicians Mutual Insurance	33,094	33,200	D+
OHIC Insurance	136,926	151,597	D
PACO Assurance	3,171	3,172	D+
Physicians Liability Insurance	40,626	75,071	E+
Physicians Reciprocal Insurers	185,333	186,924	E+
Physicians Reimbursement Fund	2,193	2,193	E+
Preferred Physicians Medical RRG	24,906	24,905	D+
Princeton Insurance	240,266	374,811	D
SCPIE Indemnity	100,198	101,675	D+
Texas Hospital Insurance Exchange	7,304	14,009	D-
Tri Century Insurance	24,238	24,238	D+
VHA Risk Retention Group	29,071	30,616	D-
Virginia Health Systems Alliance	12,058	12,242	E

A = Excellent; B = Good; C = Fair; D = Weak; E = Very Weak

Source: Weiss Ratings, Inc.

Appendix 4

Other Studies and Position Statements published by Participants in this Debate

"Florida's Medical Malpractice Insurance Crisis: An Examination of Strategic Public Policy Issues.' The Florida Center for Public Policy and Leadership at the University of North Florida. March 2003. This study is currently being updated, but will be available at http://www.unf.edu/thefloridacenter/press_room/index.shtml when complete.

"Hype Outraces Rates in Malpractice Debate; Degree of Crisis Varies Among Specialties and From State to State." *USA Today*. March 4, 2003.
http://www.usatoday.com/news/nation/2003-03-04-malpractice-cover_x.htm

"Medical Malpractice Analysis." Milliman USA on behalf of Florida Hospital Association. November 7, 2002.
http://heal-fl-health-care-pdf.netcomsus.com/resources_MillimanUSAstudy.pdf

"Medical Malpractice Insurance: Stable Losses/Unstable Rates." Americans for Insurance Reform. October 10, 2002.
http://www.insurance-reform.org/StableLosses.pdf

"Medical Malpractice: Questions and Answers." American Trial Lawyers Association.
http://www.atla.org/ConsumerMediaResources/Tier3/press_room/FACTS/medmal/icqanda.aspx

"Premium Deceit: The Failure of 'Tort Reform' to Cut Insurance Prices." Center for Justice & Democracy. July 29, 1999; reissued February 12, 2002.
http://www.insurance-reform.org/PremiumDeceit.pdf.

"President's Medical Malpractice Plan Based on Biased, Inaccurate Information; CFA Identifies Insurer Practices as Cause of Soaring Rates." Consumer Federation of America. July 31, 2002.
http://www.consumerfed.org/073102medmalrelease.html.

"Update on the Medical Litigation Crisis: Note the Result of the 'Insurance Cycle'."
U.S. Department of Health and Human Services, Office of Disability, Aging and Long-Term Care Policy. September 25, 2002.
http://www.aspe.hhs.gov/daltcp/reports/mlupd2.htm.

Statement by the Physician Insurers Association of America. January 29, 2003.
http://www.thepiaa.org/publications/pdf_files/January_29_Piaa_Statement.pdf.

Americans for Insurance Reform - Fact Sheet

California Restrictions On Malpractice Victims Have Not Affected Malpractice Premiums

Premium Data Shows California Law Is No Model For The Nation

Data released today by two consumer groups show that California's 22-year experience with the nation's most draconian limits on the rights of medical malpractice victims has failed to slow premium increases for doctors and hospitals. In fact, over the last decade, the average malpractice premium in California has grown more quickly than it has in the nation overall.

The California-based Foundation for Taxpayer and Consumer Rights and New York-based Center for Justice & Democracy (CJ&D) hired nationally recognized actuary J. Robert Hunter, former Texas Insurance Commissioner and Federal Insurance Administrator under Ford and Carter, to compare national malpractice premium trends to those in California. Hunter found that from 1991 to 2000, malpractice premiums in California have stayed close to national premium trends. The 2000 average premium per doctor in California was only 8.2 percent below that of the nation ($7,200.61 vs. $7,843.75) while the average malpractice premium in California between 1991 and 2000 actually grew more quickly (3.5 percent), than it did in the nation overall (1.9 percent.) According to Hunter, "there is not much difference in the rates or the rate of change between California and the nation based on the latest decade of experience."

In the mid-1970s, California enacted severe laws restricting the rights of patients who have been injured by malpractice, allowing them to recover no more than $250,000 in noneconomic compensation no matter how egregious the malpractice or serious the injury. The medical establishment is campaigning to spread this severe cap on damages not only to other states, but to the entire nation in recently introduced federal legislation (H.R. 4600), arguing falsely that this cap has kept premiums dramatically downward.

"If there are savings to limiting the rights and recovery of innocent victims of dangerous and culpable doctors, then insurers have not passed them on to physicians," said Jamie Court, executive director of the Foundation for Taxpayer and Consumer Rights. "California is a failed model for the national restrictions being proposed on patients. California patients have been denied adequate compensation and representation for their injuries, and California doctors have seen almost no premium savings. Only the insurers have gotten rich in the good times."

"This study disputes one of the most sensationalized fictions driving the movement to limit lawsuits against malpracticing doctors and hospitals – the notion that California's brutal restrictions on patients' rights, enacted in the mid-1970s, have slowed the growth of malpractice premiums," said CJ&D Executive Director Joanne Doroshow. "In fact, the opposite has happened. Over the last 10 years, California's premiums have grown faster than the nation's.

"This analysis has, for the first time, exposed as an insidious public relations scam the notion that California's cruel law has controlled the growth of malpractice insurance premiums. This law has had terrible consequences for many innocent people, while doing nothing to improve the affordability of liability insurance for doctors."

Year	California number of Doctors In State	U.S.A. Number of Doctors	California Med Mal Premium Earned (in thousands)	U.S.A. Med Mal Premium Earned (in thousands)	Average Med Mal Premium per Doctor in California	Average Med Mal Premium per Doctor in U.S.A.
1991	76043	631400	528056	4862170	6957.33	7700.62
1992	76387	652100	526496	5138395	6894.29	7879.77
1993	76411	670300	563004	5174055	7368.10	7719.01
1994	77311	684400	576771	5931898	7460.40	8667.30
1995	78169	720300	597680	6080639	7645.74	8441.81
1996	79048	737800	610003	5992394	7716.87	8121.98
1997	80341	756700	628858	5917038	7827.36	7819.53
1998	81762	777900	652801	6195047	7981.72	7963.81
1999	82872	797600	611785	6155241	7382.29	7717.20
2000	84675	812800	609712	6375401	7200.61	7843.75
1991 to 2000 percent change					3.5	1.9
1991 to 2000 percent change (annualized)					0.4	0.2

Sources:

Doctors USA: Statistical Abstract of the United States;

Doctors CA: California Department of Consumer Affairs;

Earned Premiums: NAIC Report On Profit By Line By State

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(AIR is a project of the Center for Justice & Democracy)

Americans for Insurance Reform

Medical Malpractice Insurance: Stable Losses/Unstable Rates 2003

***** NEWLY UPDATED STUDY BASED ON 2002 DATA*****

November 2003

Introduction and Summary of Findings

In October 2002, Americans for Insurance Reform (AIR), a coalition of over 100 consumer groups around the country, produced for the first time a comprehensive study of medical malpractice insurance from the 1970s through 2001. The study, *Stable Losses/Unstable Rates*, examined what insurers have taken in and what they've paid out over the prior 30 years. AIR found that the amount medical malpractice insurers paid out, including all jury awards and settlements, directly tracked the rate of medical inflation. On the other hand, medical insurance premiums charged by insurance companies have not corresponded to increases or decreases in payouts. Rather, they have risen and fallen in sync with the state of the economy reflecting gains or losses experienced by the insurance industry's market investments.

Now, AIR has added to this analysis newly-released insurance data from the year 2002, the year when many doctors around the country began experiencing sharp increases in insurance rates. Insurers told doctors that these premium increases were necessary because payouts and costs had dramatically risen. The data, however, does not support this view. Instead, 2002 reflects exactly the same trends as those of prior years.

This new study makes two major findings:

- First, contrary to what the insurance and medical lobbies have alleged, the years 2001 and 2002 saw no "explosion" in medical malpractice insurer payouts or costs to justify sudden rate hikes. In fact, rather than exploding, inflation-adjusted payouts per doctor dropped from 2001 to 2002. Payouts (in constant dollars) have been essentially been flat since the mid-1980s.

- Second, medical malpractice insurance premiums rose much faster in 2002 than was justified by insurance payouts. The 2002 hike is similar to the rate hikes of the past, which occurred in the mid-1980s and mid-1970s and were not connected to actual payouts. Rather, they reflect a weakened economy and losses experienced by the insurance industry's market investments and their perception of how much they can earn

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on the investment "float" (which occurs during the time between when premiums are paid into the insurer and losses paid out by the insurer) that doctors' premiums provide them.

Background

The nation's insurance companies are advancing a legislative agenda to limit liability for doctors, hospitals, HMOs, nursing homes and drug companies that cause injury. Federal and state lawmakers and regulators (and the general public) are being told by medical and insurance lobbyists that doctors' insurance rates are rising due to increasing claims by patients, rising jury verdicts and exploding tort system costs in general.

The insurance industry argues and, worse, convinces doctors to believe that patients who file medical malpractice lawsuits are being awarded more and more money, leading to unbearably high losses for insurers. Insurers state that to recoup money paid to patients, medical malpractice insurers are being forced to raise insurance rates or, in some cases, pull out of the market altogether.

Since insurers say that jury verdicts are the cause for the current "crisis" in affordable malpractice insurance for doctors, the insurance industry insists that the only way to bring down insurance rates is to limit an injured consumer's ability to sue in court.

Insurance rates for doctors have skyrocketed twice before: in the mid-1970s and in the mid-1980s, each "crisis" occurring during years of a weakened economy and dropping interest rates. Each of these periods was followed by a wave of legislative activity to restrict injured patients' rights to sue for medical malpractice. Medical and insurance lobbyists told legislators that changes in tort law were needed to reduce medical malpractice insurance rates.

However, history shows that the insurance industry has not cut, and has no plans to cut, insurance premiums as a consequence of tort restrictions. The American Insurance Association (AIA) and representatives of the American Tort Reform Association (ATRA) have already gone on record admitting this, with the AIA stating on March 13, 2002, "[T]he insurance industry never promised that tort reform would achieve specific premium savings."

The Center for Justice & Democracy's 1999 study, *Premium Deceit —the Failure of "Tort Reform" to Cut Insurance Prices*, found that tort law limits enacted since the mid-1980s have not lowered insurance rates in the ensuing years. Some states that resisted enacting any "tort reform" experienced low increases in insurance rates or loss costs relative to the national trends, and some states that enacted major "tort reform" packages saw very high rate or loss cost increases relative to the national trends. In other words, there was no correlation between "tort reform" and insurance rates.

More recently, Weiss Ratings, an independent insurance-rating agency in Palm Beach Gardens, Florida, found that between 1991 and 2002, states with caps on noneconomic damage awards saw median doctors' malpractice insurance premiums rise 48 percent -- *a greater increase than in states without caps*. In states without caps, median premiums increased only 36

percent. Moreover, according to Weiss, "median 2002 premiums were about the same" whether or not a state capped damage awards.

In January 2003, Ohio lawmakers enacted a cap on compensation for patients injured by medical malpractice. Almost immediately, all five major medical malpractice insurance companies in Ohio announced they would not reduce their rates. One insurance executive predicted his company would seek a 20 percent rate increase.

In Mississippi, lawmakers enacted a cap on medical malpractice verdicts in October 2002. Four months later, investigative news articles reported that surgeons still could not find affordable insurance and that many Mississippi doctors were still limiting their practice or walking off the job in protest.

Nevada also enacted a severe cap on compensation in 2002. Within weeks of the law's enactment, two major insurance companies proclaimed that they would not reduce insurance rates for at least another year to two, if ever. The Doctor's Company, a nationwide medical malpractice insurer, then filed for a 16.9 percent rate increase. Two other companies filed for 25 percent and 93 percent rate increases.

The "liability insurance crises" of the mid-1970s and mid-1980s were ultimately found to be caused not by legal system excesses but by the economic cycle of the insurance industry. Just as these liability insurance crises were found to be driven by this cycle and not a tort law cost explosion as many insurance companies and others had claimed, the "tort reform" remedy pushed by these advocates failed.

As this study confirms, it will fail again.

The 2003 Study

AIR, under the direction of actuary J. Robert Hunter (Director of Insurance for the Consumer Federation of America, and former Federal Insurance Administrator and Texas Insurance Commissioner), has produced a comprehensive study of medical malpractice insurance, examining specifically what insurers have taken in and what they've paid out, in constant dollars, over the last 30 years through 2002. AIR examined everything that medical malpractice insurers have paid in jury awards, settlements and other costs over the last three decades, and compared those actual costs with the premiums that insurers have charged doctors, as well as with the economic cycle of the insurance industry.

This AIR study explores whether or not there is, as the insurance industry claims, an explosion in lawsuits, jury awards or tort system costs justifying an increase in insurance premium rates, or whether premium increases simply reflect the economic cycle of the insurance industry, driven by interest rates and investments.

The Insurance Industry's Economic Cycle

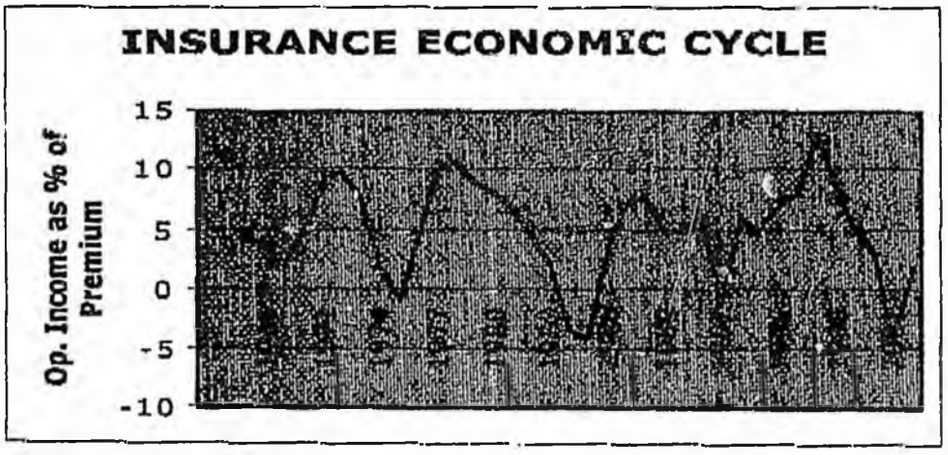
Insurers make most of their profits from investment income. During years of high interest rates and/or excellent insurer profits, insurance companies engage in fierce competition for premium dollars to invest for maximum return. Insurers severely underprice their policies and insure very poor risks just to get premium dollars to invest. This is known as the "soft" insurance market.

But when investment income decreases — because interest rates drop or the stock market plummets or the cumulative price cuts make profits become unbearably low — the industry responds by sharply increasing premiums and reducing coverage, creating a "hard" insurance market usually degenerating into a "liability insurance crisis."

A hard insurance market happened in the mid-1970s, precipitating rate hikes and coverage cutbacks, particularly with medical malpractice insurance and product liability insurance. A more severe crisis took place in the mid-1980s, when most liability insurance was impacted. Again, in 2002, the country experienced a "hard market," this time impacting property as well as liability coverages with some lines of insurance seeing rates going up 100% or more.

The following Exhibit shows the national cycle at work, with premiums stabilizing for 15 years following the mid-1980s crisis. (The 1992 data point was not a classic cycle bottom, but reflected the impact of Hurricane Andrew and other catastrophes in that year.)

Exhibit 1. The Insurance Cycle



Prior to late 2000, the industry had been in a soft market since the mid-1980s. The strong financial markets of the 1990s had expanded the usual six- to-ten year economic cycle. No matter how much they cut their rates, the insurers wound up with a great profit year when investing the float on the premium in this amazing stock and bond market. (The "float" occurs during the time between when premiums are paid into the insurer and losses paid out by the insurer —*e.g.*, there is about a 15 month lag in auto insurance and a 5 to 10 year lag in medical

malpractice.) Further, interest rates were relatively high in recent years as the Fed focused on inflation.

But in 2000, the market started to turn with a vengeance and the Fed cut interest rates again and again. This took place well before September 11th. The terrorist attacks sped up the price increases, collapsing two years of anticipated increases into a few months and leading to what some seasoned industry analysts see as gouging.[1] However, the increases we are witnessing are mostly due to the cycle turn, not the terrorist attack or any other cause. This is a classic economic cycle bottom.

Smoking Guns

AIR tested two hypotheses advanced by the insurance industry: First, if large jury verdicts in medical malpractice cases or any other tort system costs are having a significant impact on the overall costs for insurers' and are therefore the reason behind skyrocketing insurance rates, then losses per doctor should be rising faster than medical inflation over time. Second, if lawsuits or other tort costs are the cause of rate increases for doctors -- rather than decreasing interest rates and other economic factors -- those losses should be reflected in rate increases in line with such losses, not in ups and downs that instead reflect the state of the economy, the well-documented insurance economic cycle (Exhibit 1), interest rates, the stock market or the level of insurers' investment income.

AIR finds both hypotheses are completely false, demonstrated by Exhibits 2 and 3 below. First, these charts show that since 1975, medical malpractice paid claims per doctor have tracked medical inflation very closely (slightly higher than inflation from 1975 to 1985 and flat since). In other words, payouts have risen almost precisely in sync with medical inflation. Moreover, contrary to what the insurance and medical lobbies have alleged, the years 2001 and 2002 saw no "explosion" in medical malpractice insurer payouts or costs to justify sudden rate hikes. In fact, rather than exploding, inflation-adjusted payouts per doctor *dropped* from 2001 to 2002. These data confirm that neither jury verdicts nor any other factor affecting total claims paid by insurance companies that write medical malpractice insurance have had much impact on the system's overall costs over time.

Second, while payouts closely track medical inflation, medical malpractice premiums are quite another thing. They do not track costs or payouts in any direct way. Since 1975, the data show that in constant dollars, per doctor written premiums — the amount of premiums that doctors have paid to insurers — have gyrated almost precisely with the insurer's economic cycle, which is driven by such factors as insurer mismanagement and changing interest rates, not by lawsuits, jury awards, the tort system or other causes. Moreover, medical malpractice insurance premiums rose much faster in 2002 than was justified by insurance payouts. This hike is similar to the rates hikes of the past, which occurred in the mid-1980s and mid-1970s and were not connected to actual payouts.

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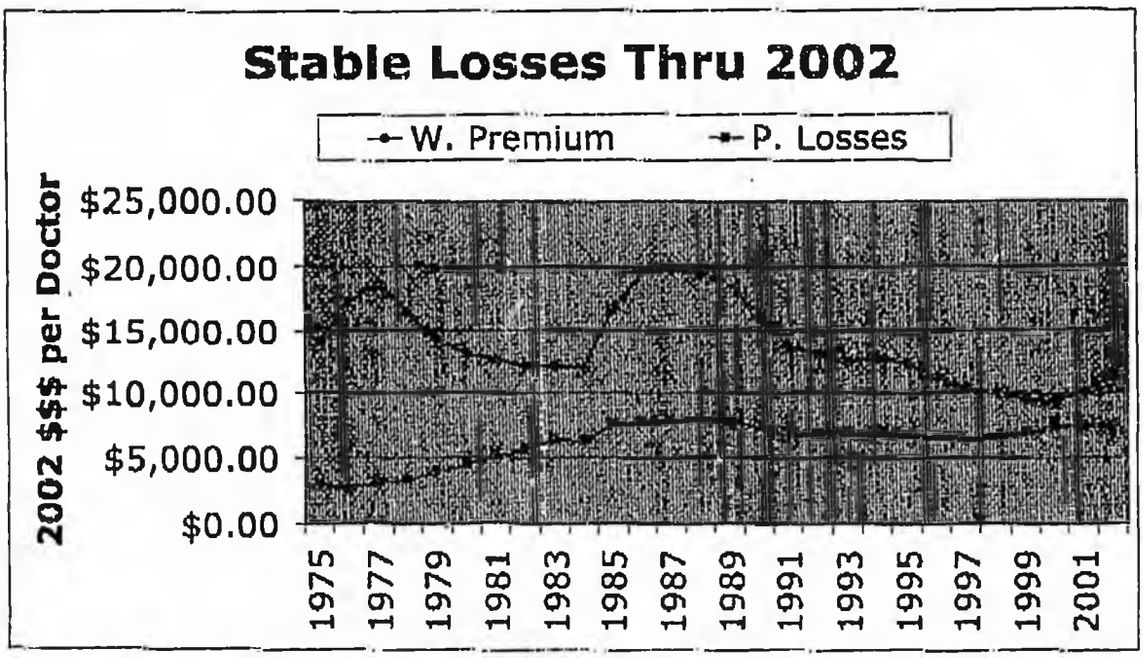
[1] "[T]here is clearly an opportunity now for companies to price gouge – and it's happening.... But I think companies are overreacting, because they see a window in which they can do it." Jeanne Hollister, consulting actuary, Tillinghast-Towers Perrin, quoted in, "Avoid Price Gouging, Consultant Warns," *National Underwriter*, January 14, 2002.

In sum, the results of AIR's analysis illustrated in Exhibits 2 and 3 are startling; premiums rise and fall with the insurance industry's economic cycle, as illustrated in Exhibit 1, but losses paid do not.

Exhibit 2



Sources:
A.M. Best and Co. special data compilation for AIR, reporting data for as many years as separately available; U.S. Bureau of the Census, 1975[2]; Inflation Index: Bureau of Labor Statistics, 1975 (1985 estimated). See Exhibit 3 for underlying data.

Definitions:

- **"W. Premium," "DPW" or "Direct Premiums Written"** is the amount of money that insurers collected in premiums from doctors during that year.
- **"P. Losses," or "Paid losses"** is what insurers actually paid out that year to people who were injured —all claims, jury awards and settlements —plus what insurance companies pay their own lawyers to fight claims.[3]

[2] We calculate the paid losses on a per doctor basis to remove from the trend we are studying the effect of the ever increasing number of doctors in America. We acknowledge that the number of doctors includes a certain number of doctors that are retired or otherwise not in the medical malpractice system, but since we are interested in overall loss trends over time, and since the percentage of doctors in that category should not vary much year to year, this fact should not significantly impact our results.

[3] "Paid losses" are a far more accurate reflection of actual insurer payouts than what insurance companies call "incurred losses." Incurred losses are not actual payouts. They include payouts but also reserves for possible future claims – *e.g.*, insurers' estimates of claims that they do not even know about yet. While incurred losses do exhibit more of a cyclical pattern, observers know that this is because in hard markets, as we are currently experiencing,