

**Medical Misdiagnosis in Oklahoma:  
Challenging the Medical Malpractice  
Claims of the Doctors' Lobby**



**Congress Watch  
April 2004**

## **Acknowledgments**

The principal authors of *Medical Misdiagnosis in Oklahoma: Challenging the Medical Malpractice Claims of the Doctors' Lobby* are Congress Watch Research Director Neal Pattison, Special Counsel Barry Boughton and Public Citizen's Legal Fellow Samantha Coulombe under the direction of Congress Watch Director Frank Clemente. Contributions also were made by Legislative Counsel Jackson Williams and Senior Researcher Taylor Lincoln.

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Public Citizen is a 160,000 member non-profit organization based in Washington, D.C., with 800 members in Oklahoma. We represent consumer interests through lobbying, litigation, research and public education. Founded in 1971, Public Citizen fights for consumer rights in the marketplace, safe and affordable health care, campaign finance reform, fair trade, clean and safe energy sources, and corporate and government accountability. Public Citizen has five divisions and is active in every public forum: Congress, the courts, governmental agencies and the media. Congress Watch is one of the five divisions.



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# Executive Summary

As conscientious physicians will attest, a misdiagnosis can have tragic consequences. It can lead to the wrong treatment of an ailment. It can imperil the patient. Oklahoma’s doctors now complain of a temporary upturn in the costs of medical malpractice insurance – but this “ailment” requires the same kind of careful evaluation and responsible treatment that any medical patient deserves.

No consumer wants to see doctors pay more for their liability insurance, even if they are specialists who earn hundreds of thousands of dollars annually. And if they have a problem, it should be solved in a fair and factual manner.

Medical leaders and their political allies have jumped to the conclusion that a recent spike in malpractice insurance rates was caused by an “explosion” of unmeritorious lawsuits and large jury awards. But reliable data does not support their assumption.

And with equal abandon, doctors have decided that the best treatment for their problem is to punish their patients by placing a \$300,000 cap on the amount victims of malpractice can receive in non-economic damages – no matter what life-threatening or life-altering injury they may have suffered from medical error or negligence.

Oklahoma is experiencing no malpractice “crisis” and, in fact, it does not even qualify for the self-serving list of “crisis” states widely publicized by the American Medical Association.

This report by Public Citizen, which relies on official government data and information from other independent sources, finds that the recent increase in Oklahoma physicians’ insurance premiums is a temporary situation caused by the cyclical nature of the insurance business – and, specifically, by the management failures of a single, dominant Oklahoma medical liability insurer.

Key findings of this report:

## **Section I: Lawsuits Are Not Responsible for Rising Medical Malpractice Insurance Premiums in Oklahoma**

- **Average medical malpractice payouts to individuals in Oklahoma declined by 16.4 percent from 1996 to 2003, when adjusted for medical services inflation.** When measured against the rising costs of medical services (using 1996 dollars), the amount paid to survivors of medical malpractice in Oklahoma declined from \$310,569 in 1996 to \$259,629 in 2003 – or 16.4 percent – over this eight-year period. Information about payouts comes from the federal National Practitioner Data Bank (NPDB), to which insurance companies are required to report all medical malpractice judgments and settlements paid on behalf of doctors nationwide.

- **Average payouts to individuals decreased 16.1 percent for Oklahoma’s largest medical malpractice insurer, PLICO, from 1996 to 2002, when adjusted for inflation.** Physicians Liability Insurance Co. (PLICO), which insures more than 80 percent of the state’s doctors, reports that its average medical malpractice payout was \$318,522 in 1996. When adjusted for medical services inflation, its average payout was only \$267,375 in 2002 (the most recent year for which its statistics are available) – a decrease of 16.1 percent. Even if not adjusted for inflation, PLICO’s average payouts increased only 5.6 percent over this period – or less than 1 percent annually.
- **Total malpractice payouts on behalf of Oklahoma doctors increased by an average of only 2 percent annually from 1996 to 2003, when adjusted for inflation.** Adjusted for medical services inflation (using 1996 dollars), the total amount of physician medical malpractice payouts in Oklahoma, according to the NPDB, increased from \$30.1 million in 1996 to \$34.3 million in 2003 – a total of 14 percent, or an average of only 2.0 percent annually. This is about the average annual increase in workers’ wages, which also affects malpractice payouts.
- **The amount of payouts made by Oklahoma’s largest malpractice insurer, PLICO, increased by an average of only 1.5 percent a year from 1996 to 2002, when adjusted for inflation.** When measured against the rising costs of medical services (using 1996 dollars), the total amount of payouts reported by PLICO increased from \$24.8 million in 1996 to \$27 million in 2002, a total of 8.9 percent, or an average of 1.5 percent annually.
- **Annually, an average of only 5.4 payouts of \$1 million or more have been made on behalf of Oklahoma physicians since 1996.** In fact, according to NPBD data, the annual number of million-dollar payouts on behalf of doctors in malpractice cases over the past eight years has never exceeded eight.
- **An average of only 12.2 percent of malpractice payouts made on behalf of Oklahoma doctors since 1996 have been for more than \$600,000 – the amount needed to be affected by a \$300,000 non-economic damages cap.** The bulk of most awards are for medical costs and economic losses, and “non-economic” damages usually represent half or less of the payout. This means a medical malpractice award would need to reach \$600,000 – or, possibly, far more – before a \$300,000 non-economic cap would have an effect. Over the past eight years, according to the NPDB, only 12.2 percent of payouts in Oklahoma were for \$600,000 or more – and the remaining 87.8 percent most likely would not have been affected by a \$300,000 cap on non-economic damages.
- **Medical malpractice premiums are much lower in Oklahoma than in neighboring states.** A comparison of 2003 medical malpractice premiums reported by the *Medical Liability Monitor* shows that doctors practicing internal medicine, general surgery and obstetrics/gynecology in Oklahoma, which generally does not cap damages, are charged much less than their colleagues in six surrounding states – Arkansas, Colorado, Kansas,

Missouri, New Mexico and Texas – five of which have some form of medical malpractice damage caps.

- **Malpractice premium prices paid by Oklahoma general surgeons and Ob/Gyns have increased at rates slower – in many cases much slower – than in neighboring states.** Since 1998, rates for Oklahoma’s general surgeons have increased 12.8 percent, and rates for its Ob/Gyns have increased 18.4 percent, according to *Medical Liability Monitor*. In comparison, general surgeons in neighboring states have paid rate increases from 24.1 percent to 219.6 percent during the same period. And Ob/Gyns in neighboring states have paid rate increases from 19.2 percent to 191.1 percent. Premium costs paid by Oklahoma internists have increased at a rate slower than all neighboring states except Missouri and Colorado.
- **The number of Oklahoma doctors rose 7.4 percent from 1995 to 2003.** In 1995 (the earliest year for which complete data is available), there were 6,252 licensed physicians practicing in Oklahoma, according to the Federation of State Medical Boards. In 2003 (the last year for which data is available), the number had risen to 6,713 – an increase of 441, or 7.4 percent. These numbers contradict the dire picture painted by the doctors lobby, which suggests the costs of medical malpractice insurance discourage doctors from practicing in Oklahoma.
- **The annual number of new medical licenses issued in Oklahoma increased 13 percent from 1995 to 2003.** In 1995 (the earliest year for which complete data is available), the Oklahoma State Board of Medical Licensure and Supervision issued 384 new licenses to M.D.s. In 2003, the number of new licenses issued rose to 434 – 13 percent greater than eight years earlier.
- **From 1990 to 2001, the ratio of physicians per 1,000 Oklahoma residents rose 15.6 percent – faster than in Colorado, a state with damage caps.** American Medical Association statistics show that Oklahoma’s ratio of physicians-to-residents grew at a rate exceeding the 14.2 percent growth from 1990-2001 in Colorado, a state that imposes a \$250,000 cap on non-economic damages in malpractice cases.
- **Oklahoma cities rank among the best places nationwide to practice medicine and run a business.** Proponents of tort law limits argue that Oklahoma faces a potential crisis in health care access – and that state doctors are considering abandoning their practices due to increasing medical malpractice insurance costs. But numerous impartial sources list Oklahoma locales among the best places to practice medicine and operate businesses. Oklahoma City and Tulsa are among the top 75 places to run a medical practice, according to *Modern Physician*. Business magazines *Inc.*, *Forbes* and *Expansion Management* give top rankings to the business climates in Oklahoma City, Tulsa and Enid. And a national real estate magazine says Oklahoma is the third best state at offering business incentives for “keeping jobs in America.”
- **Doctors allocate far more money for their salaries than they pay in malpractice premiums.** According to the federal government’s Medicare program, doctors nationally

spend an average of 52.5 percent of their practice incomes on their own salaries, 30.8 percent on such overhead as office payroll and rent, and only 3.9 percent of their practice incomes on malpractice insurance.

- **Malpractice insurance costs comprise only 1.7 percent of Oklahoma physician expenses.** According to the federal government’s Medicare actuary, Oklahoma doctors spend an average of only 1.7 percent of their practice incomes on malpractice insurance, compared with a nationwide average of 3.9 percent. This means Oklahoma doctors pay 56.4 percent less than the national average, by insurance percentage of practice income.
- **Expenditures on medical liability comprise less than 1 percent of overall health care costs.** In 2002, the federal government estimates, health care expenditures rose 9.3 percent to \$1.553 trillion. Expenditures on malpractice premiums reported to the National Association of Insurance Commissioners (NAIC) that year were \$9.6 billion – making malpractice costs only about 0.62 percent of national health care expenditures.
- **Reduced fees – not insurance rates – are the biggest financial burden on doctors.** The AMA estimates that since 1991 physician practice costs have risen by 35 percent, but Medicare payments have risen only 10 percent. That means practice costs have risen two-and-a-half times the rate of Medicare payments. This pressure has contributed greatly to doctor stress and sensitivity to any increases in their practice costs. In fact, the long-term reduction in fees paid to doctors represents a much more significant burden than the temporary spike in malpractice insurance rates that doctors recently experienced.
- **Rather than facing “runaway litigation,” doctors benefit from a claims gap.** In a landmark study, Harvard researchers found that only a small percentage of medical errors result in lawsuits. Using a sample of hospitalizations in New York State, researchers compared medical records to claims files and found that only one in 7.6 instances of medical negligence committed in hospitals results in a malpractice claim. Researchers replicating this study made similar findings in Colorado and Utah.
- **The Congressional Budget Office has rejected the defensive medicine theory.** The Congressional Budget Office (CBO) was asked to quantify the savings from reduced “defensive medicine” if Congress passed H.R. 5. This bill, which contained very stringent restrictions on patients’ ability to recover damages, passed the U.S. House in 2003. CBO declined, saying it could find “no statistically significant difference in per capita health care spending between states with and without malpractice tort limits.”

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

- **The real impact of medical malpractice in Oklahoma should be measured by the cost to patients and consumers, not the premiums paid by health care providers.** Extrapolating from Institute of Medicine (IOM) findings, we estimate there are at least 528 to 1,176 deaths in Oklahoma each year that are due to preventable medical errors in hospitals. The cost resulting from preventable medical errors to Oklahoma’s residents,

families and communities is estimated at \$204 million to \$348 million each year. But the cost of medical malpractice insurance to Oklahoma's health care providers is only \$97.2 million a year.

- **Just 3.6 percent of Oklahoma doctors are responsible for 43.4 percent of medical malpractice payouts.** According to the NPDB, these 237 doctors, all of whom have made two or more payouts, have paid nearly \$120 million in damages. Additionally, 1.3 percent of Oklahoma doctors, each of whom has paid three or more malpractice claims, were responsible for 22.9 percent of all payouts; and 84.9 percent of Oklahoma doctors have never made a medical malpractice payout since the NPDB was created in 1990.
- **Doctors with repeated malpractice claims against them suffer few consequences.** Only 14.3 percent of Oklahoma doctors who made two or more malpractice payouts were disciplined by the state's Board of Medical Licensure and Supervision. Furthermore, only 22.6 percent of Oklahoma doctors who made three or more malpractice payouts – and only 32.3 percent who made four or more malpractice payouts – were disciplined by the board.
- **Anesthesiologists' experience shows patient safety efforts do more than caps to reduce lawsuits and insurance premiums.** In 1985, the American Society of Anesthesiologists studied malpractice files from 35 different insurers and issued standards and procedures to avoid injuries. The resulting savings exceeded the dreams of any "tort reformer." In 1972, anesthesiologists were the target of 7.9 percent of all medical malpractice claims, double their proportion among physicians. But from 1985 to 2001, they were targets of only 3.8 percent of claims. From the 1970s to the 1990s, anesthesiology claims involving permanent disability or death dropped from 64 percent to 41 percent, and claims resulting in payments to plaintiffs dropped from 64 percent to 45 percent. The increased patient safety measures paid off in savings to doctors – remarkably, the average anesthesiologist's liability premium remained unchanged from 1985 to 2002 at about \$18,000 (and, if adjusted for inflation, it would be a dramatic decline). And the safety effort dramatically reduced awards. For example, during the 1990s, the median malpractice award in California, which has a stringent \$250,000 cap on non-economic damages, increased by 103 percent, but the median anesthesiology malpractice award remained constant.

### **Section III: Caps on Damages Are Unjust and Offer No Solution to Rising Premiums Caused by the Insurance Cycle**

- **A cap on non-economic damages effects only the most seriously injured patients.** A cap on non-economic damages is cruel and unusual punishment, because it affects only those who are most catastrophically harmed. According to Physician Insurers Association of America (PIAA), the average total payment between 1985 and 2001 for a "grave injury," which encompasses paralysis, was only \$454,454. This includes both economic damages (health care costs and lost wages) and non-economic damages. Since about one-third to one-half of a total award comprises non-economic damages, a \$250,000 cap affects only patients with "grave injuries."

- **Capping awards hurts children, women, seniors and minorities in particular.** Limiting medical malpractice awards for non-economic injury has a disproportionate impact on children, women, seniors and minorities. Children have no employment income, which is the basis for calculating most economic awards. One of the more significant medical injuries inflicted on women is harm to reproductive capacity, but that does not impact a woman's earning capacity, and thus does not entitle her to economic damages despite the devastating emotional impact of such a loss. Retired seniors who suffer often deplorable neglect and abuse in nursing homes and other long-term care facilities have no employment income. Capping awards also discriminates against minorities since they have lower incomes on average than whites. In some cases, low wage earners are denied the opportunity to earn more in the future due to injuries caused by medical negligence.
- **California's lower malpractice insurance premiums are due to insurance reforms, not damage caps.** In 1975 California passed MICRA (Medical Injury Compensation Reform Act), the centerpiece of which is a \$250,000 cap on non-economic damages. Ever since, this has been the model law for efforts to restrict patients' legal rights in other states. Ironically, the California experience exemplifies the success of insurance reforms, not the imposition of damage caps, at keeping malpractice rates lower. In a revolt against skyrocketing auto and homeowners insurance rates, voters passed Proposition 103 in 1988. This strong pro-consumer measure, which also applied to lines of medical malpractice insurance, instituted a 20 percent rate rollback and made it much more difficult for companies to get future rate increases. The effect on medical-malpractice insurance premiums was staggering. In the first 12 years of MICRA (1976-1988) premiums paid *increased* 190 percent, but under Proposition 103 premiums paid *declined* 2 percent from 1988-2001.
- **An analysis of malpractice payouts in Texas shows that non-economic damage awards have remained constant.** Little data exists about the amounts and percentages of total medical malpractice awards paid by doctors that go toward economic and non-economic damages. An analysis of 13 years of reports filed with the Texas Department of Insurance found that increased payouts are due to a rapid acceleration in economic damages, not non-economic damages. Economic damage awards totaled \$82.8 million in 1998 and rose to \$294.4 million by 2000 – a 212 percent increase. Non-economic damage awards, however, totaled \$60.8 million in 1988 and declined to \$40.2 million in 2000 – a drop of 34 percent. Moreover, non-economic damages comprised 42.4 percent of the total amount of medical malpractice payouts made by Texas doctors in 1998. However, the non-economic share dropped dramatically to 12 percent by 2000. In contrast, economic damages comprised 57.6 percent of all doctor payouts in 1988 but climbed to 88 percent by 2000.
- **Medical liability premium spikes are caused by the insurance cycle and mismanagement, not the legal system.** For much of the 1990s, doctors benefited from artificially lower premiums. According to the International Risk Management Institute (IRMI), insurers were on a quest for market share – “driven more by the amount of premium they could book rather than the adequacy of premiums to pay losses. In large part this

emphasis on market share was driven by a desire to accumulate large amounts of capital with which to turn into investment income.” The Congressional Budget Office recently noted that the country’s 15 biggest medical malpractice insurers saw their investment returns drop by 1.6 percent from 2000 through 2002 – a figure that corresponds to almost half of the 15 percent increase in medical malpractice premium rates estimated by the U.S. government. Medical inflation, which is running at about 5 percent a year probably accounts for the rest of the increase.

- **Congressional Budget Office links rising premiums to insurance company investment losses.** In January 2004, the Congressional Budget Office noted that the 15 biggest medical malpractice insurers saw their investment returns drop by 1.6 percent from 2000 through 2002. “That figure corresponds to almost half of the 15 percent increase in [medical malpractice premium] rates estimated by the Centers for Medicare and Medicaid Services,” the CBO reported
- **Insurance companies and their lobbyists admit caps on damages won’t lower malpractice insurance premiums.** Truly severe cases make up a small percentage of medical malpractice claims, and because the portion of the medical liability premium dollar that pays for compensation is dwarfed by the portion that pays for defense lawyer fees, caps on non-economic damages paid to patients do not lead to lower premiums for doctors. Insurance companies and their lobbyists understand this – and have said so publicly.
- **Few malpractice lawsuits are “frivolous.”** Lobbyists for the Oklahoma physicians have claimed that medical liability insurance will remain affordable only if patients can be discouraged from filing purportedly unwarranted lawsuits. In reality, the high cost of preparing a medical malpractice case discourages frivolous claims – and meritorious claims as well. Medical malpractice cases are very expensive for plaintiffs’ attorneys to bring, with out-of-pocket costs for cases settled at or near the time of trial (when most cases are settled) ranging from \$15,000 to \$25,000. If the case goes to trial, the costs can easily be doubled. These costs do not include the plaintiff’s attorney’s time, and an attorney pursuing a frivolous case incurs opportunity costs in not pursuing other cases.

## **Section I**

### **Lawsuits Are not Responsible for Rising Medical Malpractice Insurance Premiums in Oklahoma**

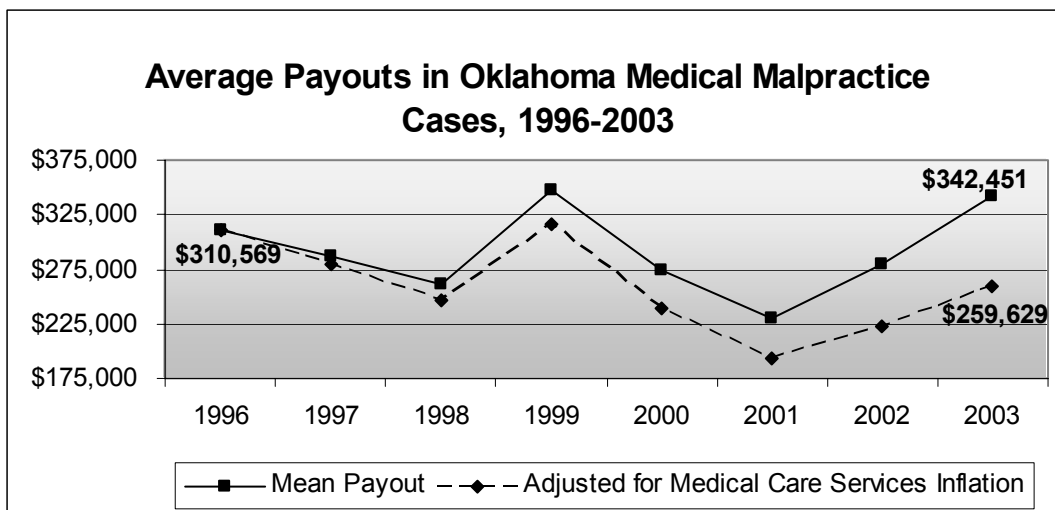
## Average Medical Malpractice Payouts in Oklahoma Have Declined by 16 Percent Since 1996 When Adjusted for Medical Services Inflation

If patients and their lawyers are routinely abusing the court system – as Oklahoma doctors and their lobbyists claim<sup>1</sup> – the alleged boom in litigation should be driving payouts to survivors of medical malpractice through the roof. But that’s not what has happened in Oklahoma.

The average medical malpractice payouts made to individuals in Oklahoma on behalf of the states’ doctors, as reported by the federal National Practitioner Data Bank (NPDB), have declined since 1995 when adjusted for medical services inflation (in 1996 dollars). Even without this adjustment, the average payout has risen at a rate well below medical services inflation. Since the bulk of a malpractice payout customarily goes to cover medical expenses, the amount of payouts can be expected to rise along with the costs of medical services. In addition, since a malpractice payout also is intended to provide compensation for lost income over a patient’s lifetime, payouts also can be expected to increase along with wages, productivity and life expectancy.

- **The average amount of Oklahoma malpractice payouts declined by 16.4 percent from 1996 to 2003, when adjusted for medical services inflation.** When measured against the rising costs of medical services (using 1996 dollars), the average (mean) amount paid to survivors of medical malpractice in Oklahoma declined from \$310,569 in 1996 to \$259,629 in 2003 – or 16.4 percent – over these eight years. [See Figure 1]

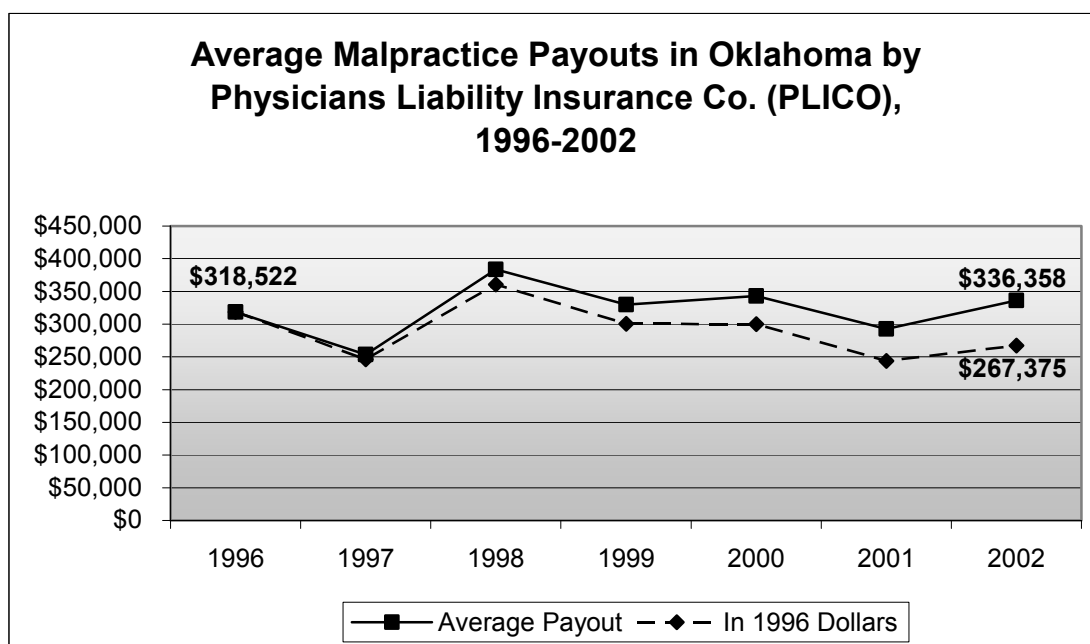
**Figure 1**



Sources: National Practitioner Data Bank, Jan. 1, 1996 – Dec. 31, 2003; Bureau of Labor Statistics – Medical Care Services CPI.

- Oklahoma’s average malpractice payouts increased at one-third the rate of medical services inflation from 1996 to 2003.** In 1996, the average (mean) malpractice payout made to an individual in Oklahoma was \$310,569. In 2003, Oklahoma’s average payout was \$342,451 – an increase of only 10.3 percent, or 1.5 percent annually. Medical services inflation over these years was 31.9 percent, or 4.6 percent annually.
- Average payouts decreased 16.1 percent for Oklahoma’s largest medical malpractice insurer from 1996 to 2002, when adjusted for inflation.** Physicians Liability Insurance Co. (PLICO), which insures more than 80 percent of the state’s doctors,<sup>2</sup> reports that its average medical malpractice payout in 1996 was \$318,522.<sup>3</sup> When adjusted for medical services inflation, its average payout in 2002 (the most recent year for which its statistics are available) was only \$267,375 – a decrease of 16.1 percent. Even not adjusted for inflation, PLICO’s average payouts increased only 5.6 percent over this period – or less than 1 percent annually. [See Figure 2]

**Figure 2**



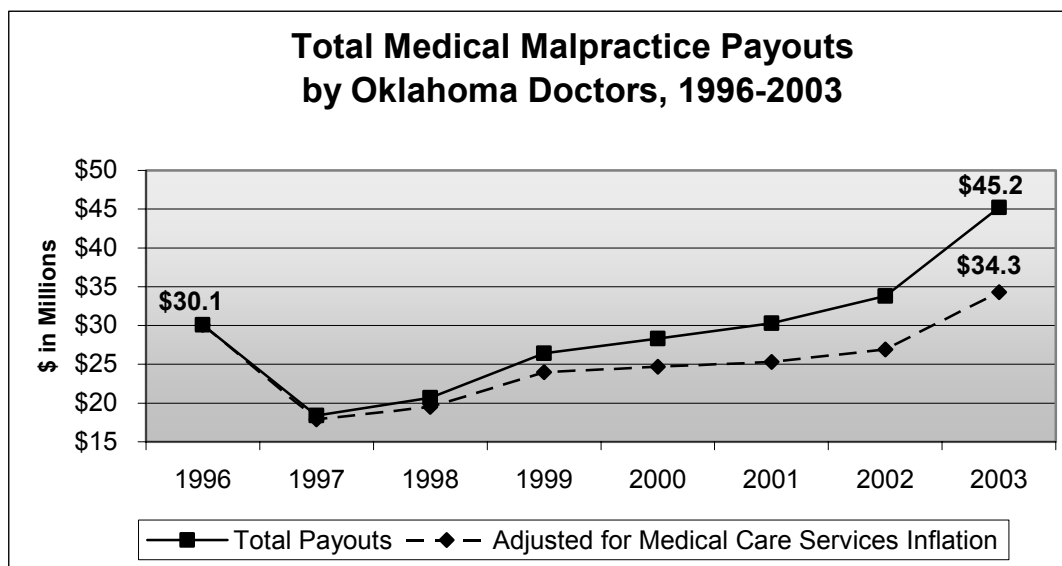
Source: PLICO presentation to the Governor's Special Tort Reform Committee, March 26, 2003.

## Total Malpractice Payouts on Behalf of Oklahoma Doctors Increased 2 Percent Annually Since 1996 When Adjusted for Medical Services Inflation

While doctors in Oklahoma complain about their “skyrocketing” malpractice insurance rates, their insurers have not experienced a dramatic spike in the total amounts they have paid to injured patients. NPDB statistics show that annual amounts paid out on behalf of physicians increased only slightly over the past eight years when adjusted for medical services inflation.

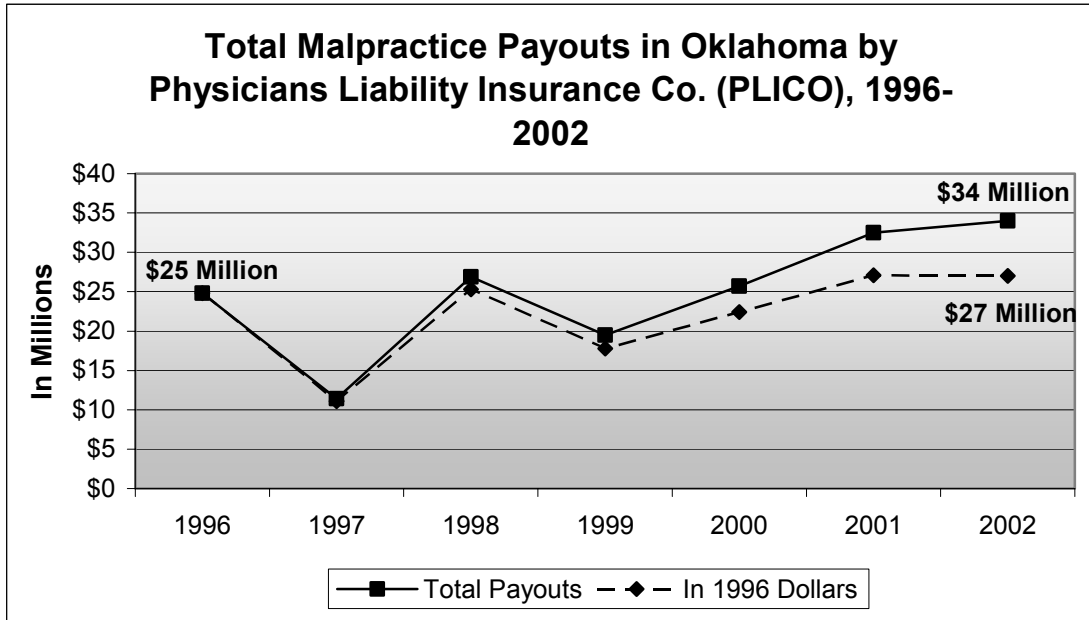
- The amount of malpractice payouts on behalf of Oklahoma physicians increased by an average of only 2 percent a year from 1996 to 2003, when adjusted for inflation.** When measured against the rising costs of medical services (using 1996 dollars), the total amount of physician medical malpractice payouts in Oklahoma increased from \$30.1 million in 1996 to \$34.3 million in 2003 – a total of 14 percent, or an average of only 2.0 percent annually. This is about the average annual increase in workers wages, which also raises malpractice payouts. [See Figure 3]
- The amount of payouts made by Oklahoma’s largest malpractice insurer increased by an average of only 1.5 percent a year from 1996 to 2002, when adjusted for inflation.** When measured against the rising costs of medical services (using 1996 dollars), the total amount of payouts made by PLICO increased from \$24.8 million in 1996 to \$27 million in 2002 (the most recent year for which its statistics are available), a total of 8.9 percent, or an average of 1.5 percent annually. [See Figure 4]

**Figure 3**



Sources: National Practitioner Data Bank, Jan. 1, 1996 – Dec. 31, 2003; Bureau of Labor Statistics – Medical Services CPI.

Figure 4



Source: PLICO presentation to the Governor's Special Tort Reform Committee, March 26, 2003.

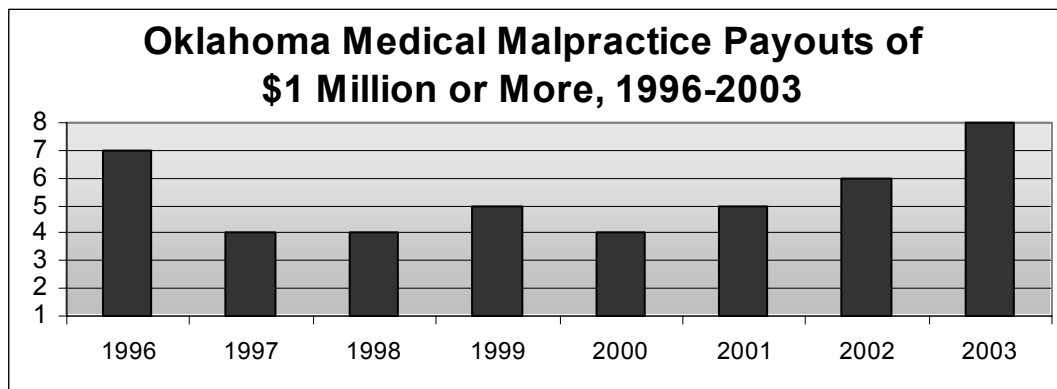
## Large Malpractice Payouts Are Too Infrequent for Damage Caps to Have a Meaningful Effect

Oklahoma physicians and their lobbyists have attempted to convince state residents and lawmakers that a “cap” on non-economic damages will stem a purported explosion of large awards in medical malpractice cases.<sup>4</sup>

In fact, there are very few medical malpractice payouts paid on behalf of Oklahoma physicians that exceed \$1 million each year, according to the NPDB, and only a small number of payouts in Oklahoma have been large enough to be affected by the \$300,000 cap being debated.

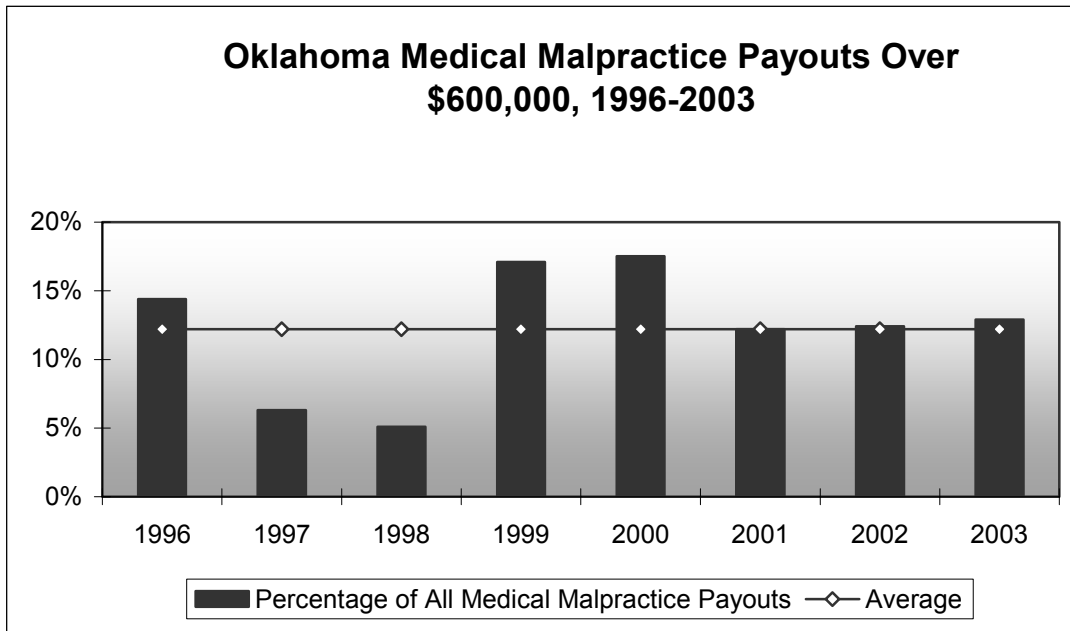
- **Annually, an average of only 5.4 payouts of \$1 million or more have been made on behalf of Oklahoma physicians since 1996.** In fact, over the past eight years, the annual number of million-dollar payouts on behalf of doctors in malpractice cases has never exceeded eight. [See Figure 5]
- **An average of only 12 percent of malpractice payouts made on behalf of Oklahoma doctors since 1996 have been for more than \$600,000 – the amount needed to be affected by a \$300,000 non-economic damages cap.** The bulk of most awards are for medical costs and economic losses, and “non-economic” damages usually represent half or less of the payout. This means a medical malpractice award would need to reach \$600,000 – or, possibly, far more – before a \$300,000 non-economic cap would have an effect. Over the past eight years, only 12.2 percent of payouts in Oklahoma were for \$600,000 or more – and the remaining 87.8 percent most likely would not have not have been affected by a \$300,000 cap on non-economic damages. The frequency of \$600,000 payouts from 2001 through 2003 reflected this average almost exactly. [See Figure 6]

Figure 5



Source: National Practitioner Data Bank, Jan. 1, 1996-Dec. 31, 2003.

Figure 6



Source: National Practitioner Data Bank, Jan. 1, 1996-Dec. 31, 2003.

## Medical Malpractice Insurance Premiums Are Much Lower in Oklahoma than in Neighboring States

Doctors have argued that caps on non-economic damages will produce lower medical malpractice insurance premiums. That is not necessarily the case, as demonstrated by a comparison of medical malpractice premiums charged for three specialties in Oklahoma, which generally does not cap damages, with premiums in six surrounding states – five of which have some form of damage caps.

In a seven-state snapshot of medical malpractice premiums, Oklahoma had the least expensive rate charged to doctors who practice internal medicine, general surgery or obstetrics/gynecology (the three specialties that are reported to the *Medical Liability Monitor*). [See Figure 7]

Additionally, the rate at which premiums have increased for general surgeons and Ob/Gyns in these states has been lowest in Oklahoma – and for internists it has been second lowest in Oklahoma. [See Figure 8]

The states in this comparison, all of which neighbor Oklahoma, include Arkansas, Colorado (a \$250,000 cap on non-economic damages), Kansas (a \$250,000 cap on non-economic damages), Missouri (an indexed \$350,000 cap on non-economic damages—currently \$565,000), New Mexico (a \$600,000 cap for all damages, but with exceptions) and Texas (which adopted a \$250,000 cap on non-economic damages last year – too recent to influence rates listed here).

- **Internists in Oklahoma pay between \$1,196 and \$10,270 less than their counterparts in neighboring states.** Oklahoma had the lowest premium cost reported in 2003 for internists, \$4,312. The next lowest was in Arkansas, \$5,508; and the highest was in Texas, \$14,582.
- **General surgeons in Oklahoma pay between \$3,589 and \$34,607 less than their counterparts in neighboring states.** Oklahoma had the lowest premium cost reported in 2003 for general surgeons, \$16,596. The next lowest was in Arkansas, \$20,185; and the highest was in Missouri, \$51,203.
- **Ob/Gyns in Oklahoma pay between \$12,414 and \$52,747 less than their counterparts in neighboring states.** Oklahoma had the lowest premium cost reported in 2003 for Ob/Gyns, \$22,454. The next lowest was in Colorado, \$34,868; and the highest was in Missouri, \$75,201.

Figure 7

**Medical Malpractice Insurance Premiums Charged in Oklahoma and Six Neighboring States, 2003**

State	Internists	General Surgeons	Ob/Gyns
<b>OKLAHOMA</b>	<b>\$4,312</b>	<b>\$16,596</b>	<b>\$22,454</b>
<b>Arkansas</b>	\$5,508	\$20,185	\$36,888
<i>Colorado</i>	\$11,180	\$39,036	\$34,868
<i>Kansas*</i>	\$6,599	\$26,909	\$41,709
<i>Missouri</i>	\$9,508	\$51,203	\$75,201
<i>New Mexico*</i>	\$8,961	\$39,430	\$44,807
<i>Texas*</i>	\$14,582	\$39,266	\$49,117

*States with damage caps prior to 2003 indicated in italics.*

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

\* Note: Premium amounts do not include additional assessments paid by physicians into state excess funds.

*Methodology:* Companies used for comparison (which were selected based on continuity over the survey period) are: Oklahoma, Physicians Liability Insurance Co. (PLICO); Arkansas, State Volunteer Mutual Insurance Co. (SVMIC); Colorado, COPIC Insurance Co.; Kansas and Missouri, Kansas Medical Mutual Physicians Mutual Liability Insurance Co. (KaMMCO); New Mexico, American Physician Insurance Corp. (APCap) and its predecessor, New Mexico Physicians Mutual Liability Co.; and Texas, Texas Medical Liability Trust (TMLT). Premiums in Texas vary by region, and the lowest available cost is cited.

- **Malpractice premium prices paid by Oklahoma general surgeons and Ob/Gyns have increased at rates slower – in many cases much slower – than in neighboring states.** Since 1998, rates for Oklahoma’s general surgeons have increased 12.8 percent, and rates for its Ob/Gyns have increased 18.4 percent. In comparison, general surgeons in neighboring states have paid rate increases from 24.1 percent to 219.6 percent during the same period. And Ob/Gyns in neighboring states have paid rate increases from 19.2 percent to 191.1 percent. [See Figure 8]
- **Premium costs paid by Oklahoma internists have increased at a rate slower than all neighboring states except Missouri and Colorado.** Since 1998, medical malpractice insurance rates for internists have increased 24.2 percent in Missouri, 32.4 percent in Colorado and 41.2 percent in Oklahoma. During the same period, internists in other states surrounding Oklahoma have paid rate increases from 59.5 percent to 159.1 percent. [See Figure 8]

**Figure 8**

**Increases in the Costs of Medical Malpractice Insurance Premiums  
in Oklahoma and Six Neighboring States,  
1998-2003**

<b>State</b>	<b>Internists</b>	<b>General Surgeons</b>	<b>Ob/Gyns</b>
<b>OKLAHOMA</b>	<b>41.2%</b>	<b>12.8%</b>	<b>18.4%</b>
<b>Arkansas</b>	159.1%	219.6%	191.1%
<i>Colorado</i>	32.4%	43.3%	19.2%
<i>Kansas</i>	59.5%	59.5%	59.5%
<i>Missouri</i>	24.2%	24.1%	24.2%
<i>New Mexico</i>	157.1%	75.6%	73.0%
<b>Texas</b>	125.1%	123.2%	77.3%

*States with damage caps prior to 2003 indicated in italics.*

Source: Medical Liability Monitor, Annual Rate Surveys, 1998-2003.

*Methodology:* Companies used for comparison (which were selected based on continuity over the survey period) are: Oklahoma, Physicians Liability Insurance Co. (PLICO); Arkansas, State Volunteer Mutual Insurance Co. (SVMIC); Colorado, COPIC Insurance Co.; Kansas and Missouri, Kansas Medical Mutual Physicians Mutual Liability Insurance Co. (KaMMCO); New Mexico, American Physician Insurance Corp. (APCap) and its predecessor, New Mexico Physicians Mutual Liability Co.; and Texas, Texas Medical Liability Trust (TMLT).

## Government Data Shows No Doctor Exodus from Oklahoma

Leaders of the medical community and ideological groups that support their push to limit patients' legal rights warn that medical malpractice costs discourage physicians from working in Oklahoma.<sup>5</sup> Statistics from state agencies, however, reveal that the state has a steadily increasing supply of doctors.

- **The number of Oklahoma doctors rose 7.4 percent from 1995 to 2003.** In 1995 (the earliest year for which complete data is available), there were 6,252 licensed physicians practicing in Oklahoma. In 2003 (the last year for which data is available) the number had risen to 6,713 – an increase of 441, or 7.4 percent. [See Figure 9]

**Figure 9**

### Oklahoma Licensed Physicians and Osteopaths Practicing In-State, 1995-2003

Year	Number of Licensed Practicing Physicians*
<b>1995</b>	6,252
<b>1996</b>	6,347
<b>1997</b>	6,504
<b>1998</b>	6,558
<b>1999</b>	6,774
<b>2000</b>	6,682
<b>2001</b>	6,631
<b>2002</b>	6,591
<b>2003</b>	6,713
<b>Increase (1995 - 2003)</b>	<b>461 7.4%</b>

*Source:* Oklahoma State Board of Medical Licensure and Supervision and Oklahoma Board of Osteopathic Examiners as reported by the Federation of State Medical Boards of the United States (FSMB), "Annual Summaries 1995 through 2003."

\* Not all physicians licensed in a state maintain practices within that state. The FSMB uses the term "licensed physicians practicing in-state" to designate physicians who are actually practicing within a specific state.

- **The annual number of new medical licenses issued in Oklahoma increased 13 percent from 1995 to 2003.** In 1995 (the earliest year for which complete data is available), the Oklahoma State Board of Medical Licensure and Supervision issued 384 new licenses to M.D.s. In 2003, the number of new licenses issued rose to 434 – 13 percent greater than eight years earlier. [See Figure 10]

**Figure 10**

**New Licenses Issued to Oklahoma M.D.s,  
1995-2003**

<b>Year</b>	<b>New Licenses Issued*</b>
<b>1995</b>	384
<b>1996</b>	409
<b>1997</b>	450
<b>1998</b>	504
<b>1999</b>	446
<b>2000</b>	383
<b>2001</b>	359
<b>2002</b>	444
<b>2003</b>	434
<b>Increase (1995-2003)</b>	<b>50 13.0%</b>

*Source:* Oklahoma State Board of Medical Licensure and Supervision.

\* Numbers for licenses issued to D.O.s are not reported by the Board of Medical Licensure and Supervision.

## Ratio of Doctors to Residents Has Increased Faster in Oklahoma than in Colorado – a State with Caps

Statistics compiled by the American Medical Association indicate the ratio of doctors-to-residents has grown steadily in Oklahoma – faster than in Colorado, which limits non-economic damages in medical malpractice cases, and at a pace comparable to Texas.

- **From 1990 to 2001, the ratio of physicians per 1,000 Oklahoma residents rose 15.6 percent – faster than in Colorado.** In comparison, the growth rate for this ratio was 14.2 percent from 1990-2001 in Colorado, which imposes a \$250,000 cap on non-economic damages in malpractice cases; and 16.5 percent in Texas. [See Figure 11]

**Figure 11**

### Physicians per 1,000 Residents in Oklahoma, Colorado and Texas – 1990-2001

Year	Oklahoma	Colorado (Caps)	Texas
<b>1990</b>	1.60	2.32	1.88
<b>1995</b>	1.77	2.57	2.06
<b>2001</b>	1.85	2.65	2.19
<b>Percent Change 1990-2001</b>	<b>+15.6%</b>	<b>+14.2%</b>	<b>+16.5%</b>

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

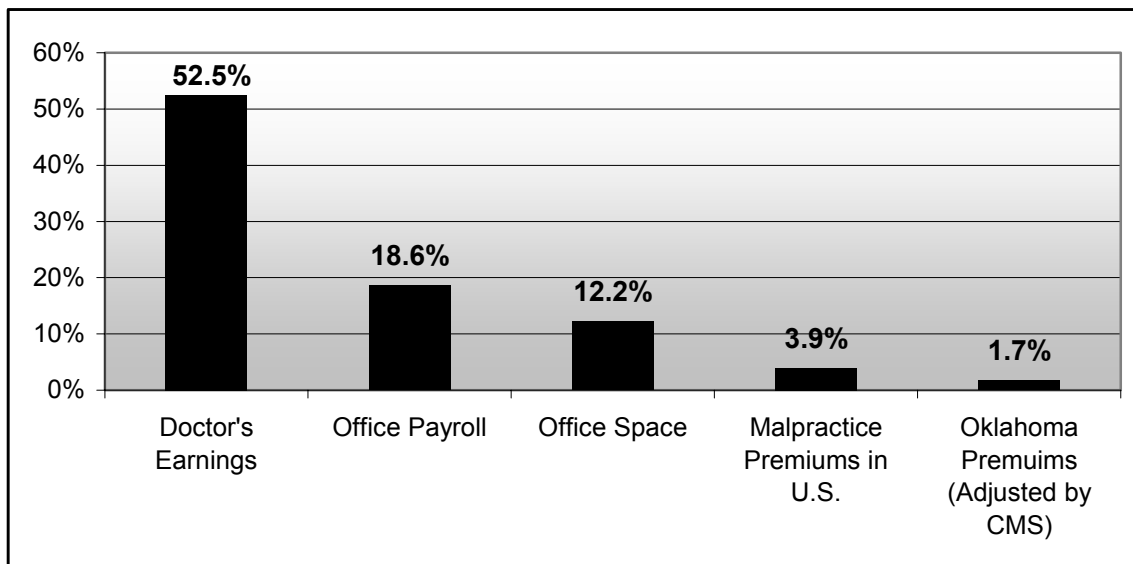
## Malpractice Insurance Costs Comprise Only 1.7 Percent of Oklahoma Physician Expenses

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

- **Doctors allocate far more money for their salaries than they pay in malpractice premiums.** According to the federal government's Medicare program, doctors nationally spend an average of 52.5 percent of their practice incomes on their own salaries, 30.8 percent on such overhead as office payroll and rent, and only 3.9 percent of their practice incomes on malpractice insurance.<sup>6</sup> [See Figure 12]
- **Oklahoma doctors spend less than half the national average for medical malpractice insurance, as a percent of physician expenses.** According to the federal government's Medicare program, Oklahoma doctors spend an average of only 1.7 percent of their practice incomes on malpractice insurance, compared with a nationwide average of 3.9 percent.<sup>7</sup> This means Oklahoma doctors pay 56.4 percent less than the national average.

Figure 12

### Where Doctors' Practice Income Goes, 2004



Source: "Annual Percent Change in the Revised and Rebased Medicare Economic Index, 2004 – Cost Categories and Price Measures," Centers for Medicare and Medicaid Services (CMS), Nov. 7, 2003.

- **Expenditures on medical liability comprise less than 1 percent of overall health care costs.** In January 2004, when the federal Centers for Medicare and Medicaid Service (CMS) actuaries released a 13-page report on growth in health care expenditures, the subject of medical malpractice costs rated only an 11-word mention. That’s probably because 2002 health care expenditures rose 9.3 percent to \$1.553 trillion,<sup>8</sup> yet expenditures on malpractice premiums reported to the National Association of Insurance Commissioners (NAIC) that year were only \$9.6 billion – making malpractice costs about .0062 percent of national health care expenditures.<sup>9</sup>

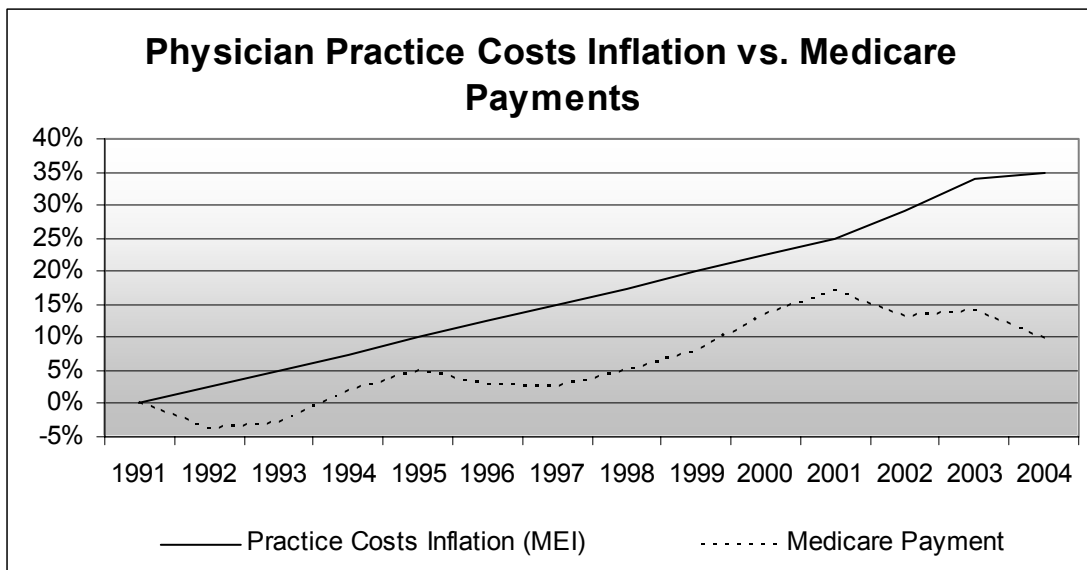
## Reduced Fees – Not Insurance Rates – Are the Biggest Financial Burden on Doctors

Doctors across the country have seen their fees slashed in recent years as managed care companies tried to increase profits, and government programs, such as Medicare and Medicaid, tried to cut costs.

Medicare reimbursement rates no longer come close to keeping pace with increases in doctors' practice expenses. The AMA estimates that since 1991 physician practice costs have risen by 35 percent, but Medicare payments have risen only 10 percent. That means practice costs have risen two-and-a-half times the rate of Medicare payments. [See Figure 13]

This pressure on fees has contributed greatly to doctor stress and sensitivity to any increases in their practice costs. In fact, the long-term reduction in fees paid to doctors represents a much more significant burden than the recent, temporary spike in malpractice insurance rates. The tort system is a convenient whipping boy for doctors who will continue to chafe from cost containment measures, but survivors of medical negligence should not be made to compensate for declining reimbursement rates

**Figure 13**



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

## Oklahoma Cities Are Ranked Among the Best Places to Practice Medicine and Run a Business

Proponents of tort law limits argue that Oklahoma faces a potential crisis in health care access – and that state doctors are considering abandoning their practices due to increasing medical malpractice insurance costs.<sup>10</sup> Furthermore, it is argued, Oklahoma is losing business of all kinds because its civil litigation system is “out of control.”<sup>11</sup> The business and medical communities claim that restricting plaintiffs’ legal rights, including caps on non-economic damages, will make Oklahoma “more attractive to physicians and job-creating businesses.”<sup>12</sup>

However, numerous impartial sources already list Oklahoma and Oklahoma cities near the top of lists of the best places to practice medicine and operate businesses. Consider the following:

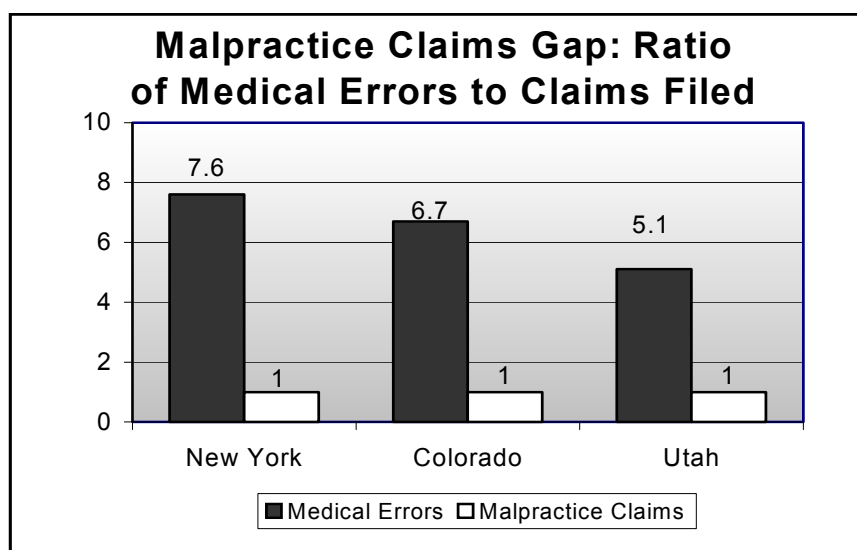
- **Oklahoma City and Tulsa are among the top 75 places to run a medical practice, according to *Modern Physician*.** In October 2003, *Modern Physician* published its list of the top 75 places to run a medical practice in the United States. The criteria used to determine the rankings included population, malpractice premiums, Medicare reimbursement levels, labor costs and state income taxes. Oklahoma City ranked 39<sup>th</sup> and Tulsa 62<sup>nd</sup> on the list.<sup>13</sup>
- **Two Oklahoma Cities are among the top 25 cities for doing business in America, according to *Inc. magazine*.** In March 2004, *Inc. magazine* published its list of the top cities in America for doing business. The primary criteria used to determine the rankings were current and historical job growth. Among large cities, Oklahoma City ranked 24<sup>th</sup> and among small cities, Enid ranked 25<sup>th</sup>.<sup>14</sup>
- **Tulsa has the lowest and Oklahoma City the third lowest cost of doing business nationwide according to *Forbes*.** In May 2003, *Forbes* magazine published its list of the “Best Places for Business and Careers.” One of the criteria used to determine the overall rankings was the cost of doing business. Tulsa had the lowest cost of doing business and ranked 35<sup>th</sup> on the overall list. Oklahoma City had the third lowest cost of doing business and ranked 18<sup>th</sup> on the overall list.<sup>15</sup>
- **Oklahoma City and Tulsa rank in the top 15 of *Expansion Management’s 2004 list of America’s 50 hottest cities for business expansions and relocations*.** In January 2004, *Expansion Management* published its list of the 50 hottest cities for business relocations and expansions. Oklahoma City ranked 9<sup>th</sup> and Tulsa ranked 15<sup>th</sup> on the list.<sup>16</sup>
- **Oklahoma is one of the top ten “pro-business” states, according to *Pollina Corporate Real Estate, Inc.*** In November 2003, Pollina Corporate Real Estate, Inc. published its study entitled “Keeping Jobs in America” in which it ranked the top ten pro-business states in the country. The study looked at many factors including the economic incentives offered to businesses. Oklahoma ranked third best in having policies that enhance the business environment.<sup>17</sup>

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

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

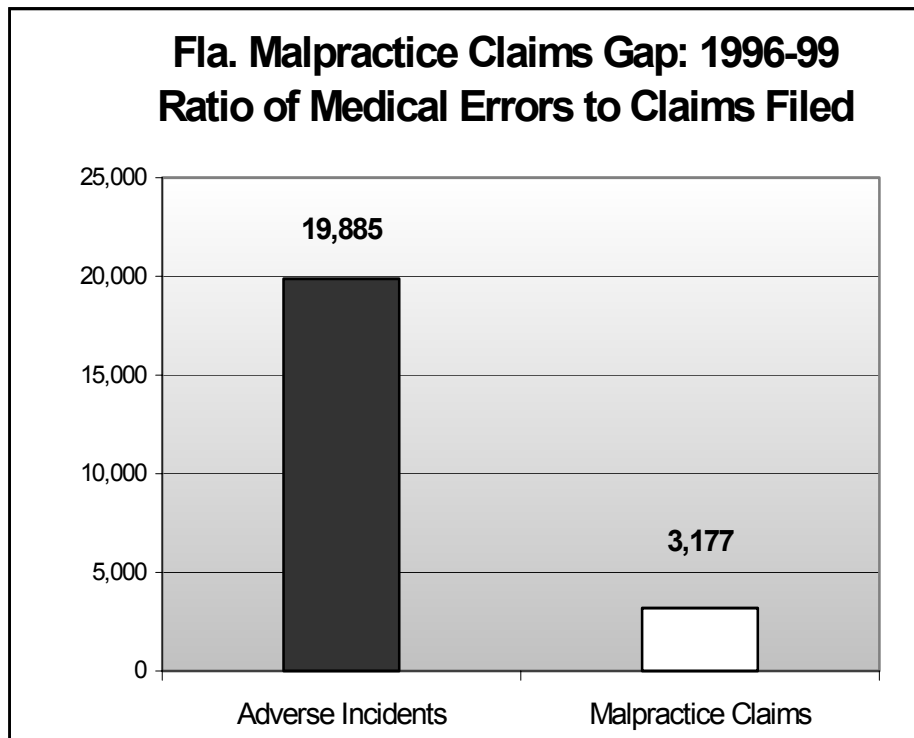
- A landmark Harvard Medical Practice Study found that only a small percentage of medical errors result in lawsuits.** Twelve years ago, Harvard researchers using a sample of hospitalizations in New York State compared medical records to claims files. They found that only one in 7.6 instances of medical negligence committed in hospitals results in a malpractice claim.<sup>18</sup> Researchers replicating this study made similar findings in Colorado and Utah.<sup>19</sup> [See Figure 14]
- Florida’s health agency shows a similar claims gap.** A Florida statute requires hospitals to report “adverse incidents,” defined as “an event over which health care personnel could exercise control” that results in death or injury. Tables prepared by Florida’s Agency for Health Care Administration have compared reports of adverse incidents to filing of new malpractice claims. From 1996 through 1999 (the most recent year for which data is available), Florida hospitals reported 19,885 incidents but only 3,177 medical malpractice claims.<sup>20</sup> In other words, for every six preventable medical errors only one claim is filed. [See Figure 15]

**Figure 14**



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

**Figure 15**



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

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

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

- **A search of the scholarly literature on medicine will turn up dozens of studies documenting the incidence of medical errors, but not one peer-reviewed study documenting purely defensive medicine.** One might laugh at the spectacle of a lobbying campaign constructed around a flimsy theory unsupported by any empirical evidence. Unfortunately, the evidence *disproving* the theory is so overwhelming and compelling as to be truly frightening. Several recent studies demonstrate that current disincentives to unsafe and sloppy practices are inadequate, and show how much more dangerous medical care would be if deterrents were further weakened.
- **The Congressional Budget Office has rejected the defensive medicine theory.** The Congressional Budget Office (CBO) was asked to quantify the savings from reduced “defensive medicine” if Congress passed H.R. 5. This bill, which contained very stringent restrictions on patients’ ability to recover damages, passed the U.S. House in 2003. CBO declined, saying:

Estimating the amount of health care spending attributable to defensive medicine is difficult. Most estimates are speculative in nature, relying, for the most part, on surveys of physicians’ responses to hypothetical clinical situations, and clinical studies of the effectiveness of certain intensive treatments. Compounding the uncertainty about the magnitude of spending for defensive medicine, there is little empirical evidence on the effect of medical malpractice tort controls on spending for defensive medicine and, more generally, on overall health care spending.

A small number of studies have observed reductions in health care spending correlated with changes in tort law, but that research was based largely on a narrow part of the population and considered only hospital spending for a small number of ailments. ...[u]sing a different data set, CBO could find no statistically significant difference in per capita health care spending between states with and without malpractice tort limits.<sup>21</sup>

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

mitigate defensive practices. According to some research, managed care provides a financial incentive not to offer treatments that are unlikely to have medical benefit.”<sup>22</sup>

A 1996 study by two economists has been cited by the Bush Administration to argue that tort “reform” will yield a 5 to 9 percent savings in health care costs from decreased defensive medicine. “However,” said the GAO, “this study did not control for other factors that can affect hospital costs, such as the extent of managed care penetration in different areas. When controlling for managed care penetration in a 2000 follow-up study, the same researchers found that the reductions in hospital expenditures attributable to direct tort reforms dropped to about 4 percent. Moreover, preliminary findings from a 2003 study [by CBO] that replicated and expanded the scope of these studies to include Medicare patients treated for a broader set of conditions failed to find any impact of state tort laws on medical spending.”<sup>23</sup>

- **Defensive medicine hasn’t prevented wrong-patient surgery.** New York hospitals reported 27 instances of invasive procedures performed on the wrong patient between April 1998 and December 2001.<sup>24</sup> There were nine such instances in Florida in 2001.<sup>25</sup> In trying to determine how such shocking errors could occur, researchers analyzed one case in detail. The case study determined that medical personnel had ignored “many seemingly clear signals that they were subjecting the wrong patient to an invasive procedure.” In this case, “defensive medicine” measures would have included follow-up questioning or record-checking when the patient told personnel she had not been admitted for cardiac treatment. Surely if the medical providers were frightened of lawsuits they would have made such minimal inquiries.
- **Defensive medicine hasn’t prevented medication errors.** An Auburn University study of 36 hospitals and nursing homes in Colorado and Georgia found that on average, 19 percent of medication doses were given in error, with 7 percent judged to be potentially harmful.<sup>26</sup> The authors said this amounts to about 40 potential adverse drug events per day in a typical 300-patient facility. The errors were made in spite of the presence of observers from the research team – who could easily have been called as witnesses in a medical liability lawsuit. An earlier study by Boston researchers estimated that there are some 500 preventable adverse drug events in the average hospital each year, in spite of the fact that “drug injuries frequently result in malpractice claims, and in a large study of closed claims... accounted for the highest total expenditure of any type of procedure-related injury.”<sup>27</sup>
- **Defensive medicine hasn’t prevented mammography errors.** The *New York Times* reported in June 2002 some very disturbing facts about errors committed by radiologists in reading mammograms.<sup>28</sup> Studies indicate that some doctors and clinics miss as many as one in three cancers. Despite the possibility of lawsuits, doctors with no aptitude for mammography continue to read mammograms. Clinics continue to employ doctors who read too few mammograms to keep their skills sharp. It appears that only reviews by regulators spur doctors and clinics to meet minimum standards.

- **Defensive medicine hasn't prevented hospital infections.** The *Chicago Tribune* reported on July 21, 2002 that some 75,000 Americans die each year because of infections acquired in hospitals that “were preventable, the result of unsanitary facilities, germ-laden instruments, unwashed hands and other lapses.”<sup>29</sup> If medical providers fear being sued over the slightest lapse, why would doctors and nurses neglect to take the most elementary precautions of washing their hands and changing scrub uniforms? Why would American hospitals “have collectively pared cleaning staffs by 25 percent since 1995”?<sup>30</sup> Previously, consultants retained by medical provider groups have argued that medical providers *overspend* on precautionary measures by five to nine percent.<sup>31</sup>
- **Defensive medicine hasn't caused hospitals to keep nursing staffs up-to-strength.** Two reports published in the past 6 months concluded that patients in hospitals where nurses had heavier workloads had a higher risk of dying.<sup>32</sup> One report found specifically that each additional patient per nurse corresponded to a 7 percent increase in both patient mortality and deaths following complications.<sup>33</sup> Nevertheless, nursing shortages persist, even though the defensive medicine theory predicts.

## **Section II**

### **The Real Medical Malpractice Crisis Is Inadequate Patient Safety**

## Oklahoma Patients & Consumers Suffer the Real Costs of Medical Malpractice

In 1999, the Institute of Medicine (IOM) estimated that from 44,000 to 98,000 Americans die in hospitals every year from *preventable* medical errors.<sup>34</sup> The IOM also estimated the costs to individuals, their families and society at large for these medical errors at \$17 billion to \$29 billion a year. These costs include disability and health care costs, lost income, lost household production and the personal costs of care.

The true impact of medical malpractice in Oklahoma should be measured by the cost to patients and consumers, not the premiums paid by doctors and other health care providers to their insurance companies. Extrapolating from the IOM findings, we estimate that there are at least 528 to 1,176 deaths in Oklahoma each year that are due to preventable medical errors in hospitals. The cost resulting from preventable medical errors to Oklahoma's residents, families and communities is estimated at \$204 million to \$348 million each year. But the cost of medical malpractice insurance to Oklahoma's health care providers is only \$97.2 million a year. [See Figure 16]

**Figure 16**

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

<p><b><u>528 – 1,176</u></b> <b>Annual Deaths Due to Preventable Medical Errors in Hospitals</b></p> <p><b><u>\$204 million - \$348 million</u></b> <b>Annual Costs Resulting from Preventable Medical Errors in Hospitals</b></p> <p><b><u>\$97.2 million</u></b> <b>Cost of Oklahoma Health Care Providers' Annual Medical Malpractice Premiums</b></p>
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*Sources:* Preventable deaths and costs are prorated based on population and based on estimates in *To Err Is Human*, Institute of Medicine, November 2000. Malpractice premiums are based on "Medical Malpractice Net Premium and Incurred Loss Summary," National Association of Insurance Commissioners, July 18, 2002.

## 3.6 Percent of Doctors Are Responsible for 43 Percent of Oklahoma Medical Malpractice Payouts

The insurance and medical communities argue that medical malpractice litigation constitutes a giant “lottery,” in which lawsuits are purely random events bearing no relationship to the care given by a physician. If the tort system is a lottery, it is clearly rigged, because some doctors’ numbers come up more often than others. According to the federal government’s NPDB, which was created in September 1990 to track malpractice judgments and settlements against physicians, a small percentage of doctors have paid multiple claims, and it is these doctors who are responsible for much of the malpractice in Oklahoma.

- According to the NPDB, just 3.6 percent of Oklahoma doctors have been responsible for 43.4 percent of all malpractice payouts to patients. Overall, these 237 doctors, all of whom have made two or more payouts, have paid nearly \$120 million in damages since September 1990. [See Figure 17]
- Even more surprising, just 1.3 percent of Oklahoma doctors (84), each of whom has made three or more malpractice payouts, were responsible for 22.9 percent of all payouts.
- Only 0.2 percent of Oklahoma doctors (15), each of whom has made five or more malpractice payouts, were responsible for 9.1 percent of all payouts.
- 84.9 percent of Oklahoma doctors have never made a medical malpractice payout since the NPDB was created in 1990.

**Figure 17**

### Number and Amounts of Medical Malpractice Payouts to Patients Paid by Oklahoma Doctors, Sept. 1, 1990-Dec. 31, 2003

Number of Payout Reports	Number of Doctors Who Made Payouts	Total Number of Payouts	Percent/Total Doctors (6,604)*	Percent of Total Number of Payouts	Total Amount of Payouts
All	999	1,347	15.1%	100%	\$341,196,650
1	762	762	11.5%	56.6%	\$221,361,350
2 or more	237	585	3.6%	43.4%	\$119,835,300
3 or more	84	308	1.3%	22.9%	\$58,824,000
4 or more	31	171	0.5%	12.7%	\$28,793,500
5 or more	15	122	0.2%	9.1%	\$8,762,500

Source: National Practitioner Data Bank, Sept. 1, 1990 to Dec. 31, 2003.

\* Based on number of physicians in 1997, the midpoint of the time period studied, as reported by the American Medical Association.

## Doctors with Repeated Malpractice Payouts Suffer Few Consequences

The Oklahoma Board of Medical Licensure and Supervision and the state’s health care providers have not done enough to rein in those doctors who repeatedly make medical errors and commit medical negligence. According to the National Practitioner Data Bank and Public Citizen’s analysis of NPDB data, disciplinary actions (license suspension or revocation, or a limit on clinical privileges) have been few and far between for Oklahoma physicians. [See Figure 18]

- Only 14.3 percent (34 out of 237) of Oklahoma doctors who made two or more malpractice payouts were disciplined by the board.
- Only 22.6 percent (19 out of 84) of Oklahoma doctors who made three or more malpractice payouts were disciplined by the board.
- Only 32.3 percent (10 out of 31) of Oklahoma doctors who made four or more malpractice payouts were disciplined by the board.
- 46.7 percent (7 out of 15) of Oklahoma doctors who made five or more malpractice payouts were disciplined by the board.

**Figure 18**

### Number of Oklahoma Doctors with Two or More Medical Malpractice Payouts Who Have Been Disciplined (Reportable Licensure Actions), 1990 – 2003

Number of Payout Reports	Number of Doctors Who Made Payouts	Number of Doctors with One or More Reportable Licensure Actions	Percent of Doctors with One or More Reportable Licensure Actions
2 or more	237	34	14.3%
3 or more	84	19	22.6%
4 or more	31	10	32.3%
5 or more	15	7	46.7%
10 or more	6	5	83.3%

Source: National Practitioner Data Bank, Sept. 1, 1990 – Dec. 31, 2003.

## Examples of Repeat Offender Doctors Who Have Gone Undisciplined

The extent to which Oklahoma doctors make multiple payouts to patients for medical malpractice claims and are not disciplined is illustrated by the following NPDB descriptions of seven physicians licensed in Oklahoma who have made between four and six malpractice payouts totaling over \$750,000 yet have not been disciplined by the state. The NPDB does not disclose to the public the identity of these physicians.

- **Physician Number 95359** made at least four malpractice payments between 1996 and 2003, for performing surgery on a wrong body part, an improper performance of surgery, and improper choice of delivery method and an unspecified obstetrics error. The damages add up to \$5,375,000.
- **Physician Number 31428** made at least four malpractice payments between 1992 and 1998, for an improperly managed labor, an improper choice of delivery method, a failure to diagnose and an unspecified obstetrics error. The damages add up to \$2,670,000.
- **Physician Number 31390** made at least four malpractice payments between 1995 and 1998, three times for improperly performing surgeries and a wrong diagnosis. The damages add up to \$1,935,000.
- **Physician Number 40224** made at least four malpractice payments between 1992 and 2003 twice for unspecified obstetrics errors, a retained foreign body during surgery and failure to obtain consent in surgery. The damages add up to \$1,775,000.
- **Physician Number 96568** made at least four malpractice payments between 1996 and 2000, twice for unspecified surgical errors, an unnecessary surgery and an unspecified treatment error. The damages add up to \$1,355,000.
- **Physician Number 31353** made at least five malpractice payments between 1992 and 2000, twice for unspecified diagnosis errors, an improper positioning during surgery, an improper management of surgery and an unnecessary surgery. The damages add up to \$877,500.
- **Physician Number 43800** made at least six malpractice payments between 1992 and 2000, four times for unspecified surgical errors, an improper management of surgery and an unspecified treatment error. The damages add up to \$827,500.

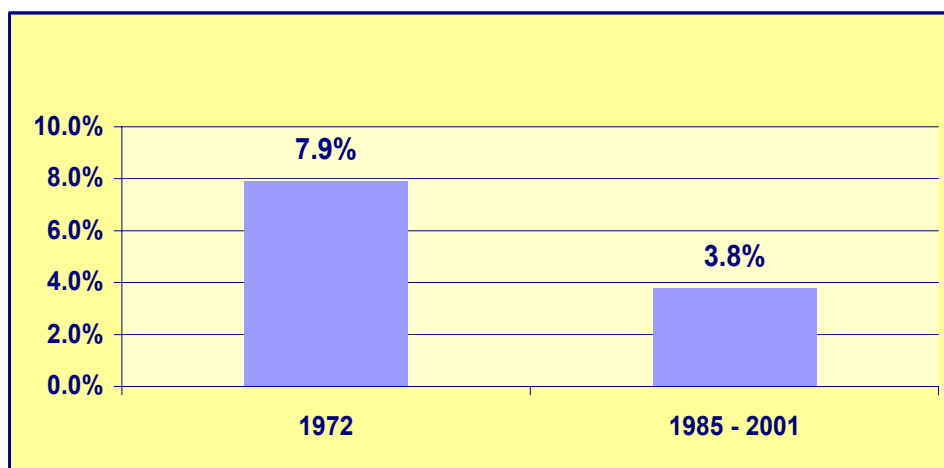
## Anesthesiologists' Experience Shows Patient Safety Efforts Do More than Caps to Reduce Lawsuits and Insurance Premiums

Generally speaking, doctors have resisted courts' findings of negligent medical care, choosing to fight the system rather than learn from mistakes. But an exception was the American Society of Anesthesiologists (ASA), which in 1985 initiated an effort to study malpractice claims. ASA established a Closed Claims Project at the University of Washington Medical School and gathered claims files from 35 different insurers. The outcome of this Manhattan Project-like commitment was the issuance of standards and procedures to avoid injuries that resulted in savings beyond the wildest dreams of any "tort reformer."

- The number and severity of claims dropped dramatically. In 1972, anesthesiologists were the target of 7.9 percent of all medical malpractice claims, double their proportion among physicians. But from 1985 to 2001, they were targets of only 3.8 percent of claims. [See Figure 19]
- In the 1970s, 64 percent of anesthesiology claims involved permanent disability or death; by the 1990s, only 41 percent did. [See Figure 20]
- The percent of anesthesia claims resulting in payments to plaintiffs dropped from 64 percent in the 1970s to 45 percent in the 1990s. [See Figure 21]

**Figure 19**

### Percent of Malpractice Claims Involving Anesthesiologists

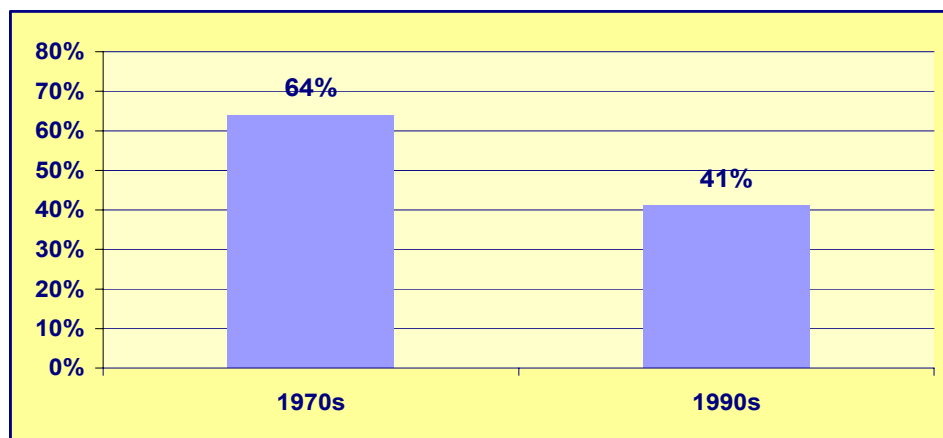


Sources: U.S. Department of Health, Education and Welfare, Secretary's Commission on Medical Malpractice, 1973; Physician Insurers Association of America, Cumulative Data Sharing Report, January 1, 1985 – December 31, 2001.

- The increased patient safety measures paid off in savings to doctors. Remarkably, the average anesthesiologist’s liability premium remained unchanged from 1985 to 2002 at about \$18,000 (and, if adjusted for inflation, it would be a dramatic decline). [See Figure 22]
- The safety effort proved far superior to damage caps in holding down awards. For example, during the 1990s, the median malpractice award in California, home to the most stringent cap on non-economic damages, increased by 103 percent; the median anesthesiology malpractice award remained constant.

**Figure 20**

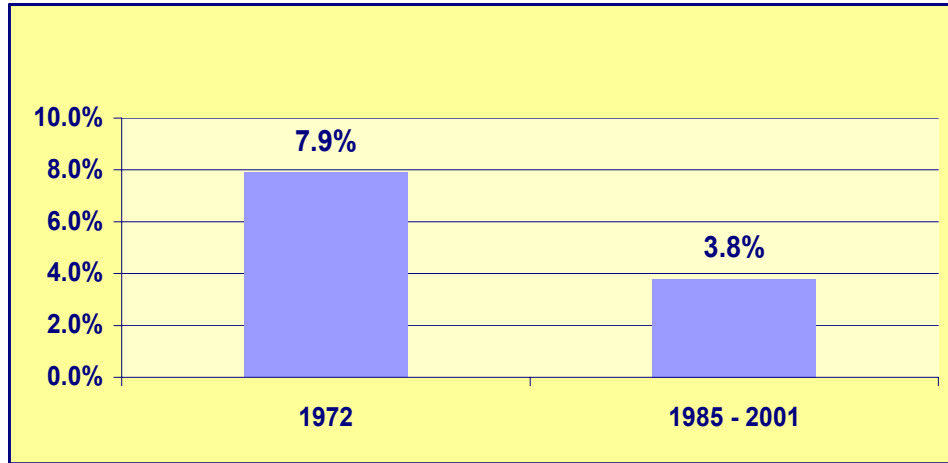
**Anesthesia Claims Involving Permanent Disability or Death,  
1970s and 1990s**



Source: American Society of Anesthesiologists, “Closed Claims Project Shows Safety Evolution,” 2001.

**Figure 21**

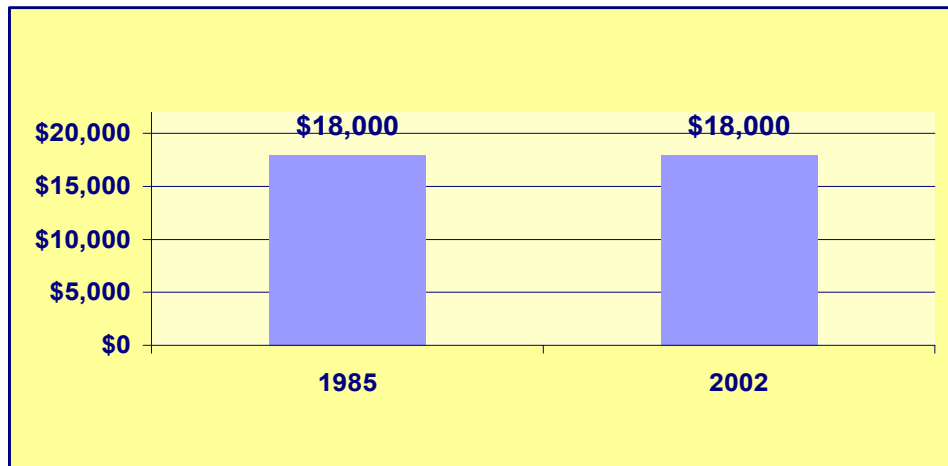
**Percent of Anesthesia Claims Closed with Payment,  
1970s and 1990s**



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

**Figure 22**

**Average Premium for Anesthesiologists  
1985 and 2002**



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

## **Section III**

### **Caps on Damages Are Unjust and Offer No Solution to Rising Premiums Caused by the Insurance Cycle**

## Caps on Damages Are Unjust

Doctors and their lobbyists in Oklahoma are pushing for a \$300,000 limit on non-economic damages, also known as “pain-and-suffering,” in medical malpractice cases. Such a cap, widely promoted by medical associations and their political allies, has not been proven to effectively lower medical malpractice insurance costs. It does, however, penalize the most severely injured patients while reducing physician, hospital and HMO accountability, thereby lessening deterrence against errors and negligence.

- **“Non-economic” damages are not as easy to quantify as lost wages or medical bills, but they compensate real injuries.** So-called “non-economic” damages are awarded for the pain and suffering that accompany any loss of normal functions (e.g. blindness, paralysis, loss of sexual function, lost bowel and bladder control, loss of limb) and inability to engage in daily activities or to pursue hobbies, such as hunting and fishing. This category also encompasses damages for disfigurement and loss of fertility.
- **A cap on non-economic damages effects only the most seriously injured patients.** A cap on non-economic damages is cruel and unusual punishment, because it affects only those who are most catastrophically harmed. According to Physician Insurers Association of America (PIAA), the average total payment between 1985 and 2001 for a “grave injury,” which encompasses paralysis, was only \$454,454. This includes both economic damages (health care costs and lost wages) and non-economic damages. Since about one-third to one-half of a total award comprises non-economic damages, a \$250,000 cap affects only patients with “grave injuries.”<sup>35</sup>
- **Capping awards hurts children, women, seniors and minorities in particular.** Limiting medical malpractice awards for non-economic injury has a disproportionate impact on children, women and minorities. Children have no employment income, which is the basis for calculating most economic awards. One of the more significant medical injuries inflicted on women is harm to reproductive capacity, but that does not impact a woman’s earning capacity, and thus does not entitle her to economic damages despite the devastating emotional impact of such a loss. Retired seniors who suffer often deplorable neglect and abuse in nursing homes and other long-term care facilities have no employment income. Capping awards also discriminates against minorities since they have lower incomes on average than whites. In some cases, low wage earners are denied the opportunity to earn more in the future due to injuries caused by medical negligence.
- **No evidence supports the claim that jury verdicts are random “jackpots.”** Studies conducted in California, Florida, North Carolina, New York and Ohio have found that jury verdicts bear a reasonable relationship to the severity of the harm suffered.<sup>36</sup> In total, the studies examined more than 3,500 medical malpractice jury verdicts and found a consistent relationship between the severity of the injury and the size of the verdict. Uniformly the authors concluded that their findings did not support the criticism that jury verdicts are frequently unpredictable and irrational.

## California's Lower Malpractice Insurance Premiums Are Due to Insurance Reforms not Damage Caps

The experience with medical malpractice insurance rates in California is heavily promoted by doctors and insurance companies as justification for caps on non-economic damages. In 1975 California passed MICRA (Medical Injury Compensation Reform Act), the centerpiece of which is a \$250,000 cap on non-economic damages (which does not even allow for inflation increases). Ever since, this has been the model law for efforts to restrict patients' legal rights in other states.

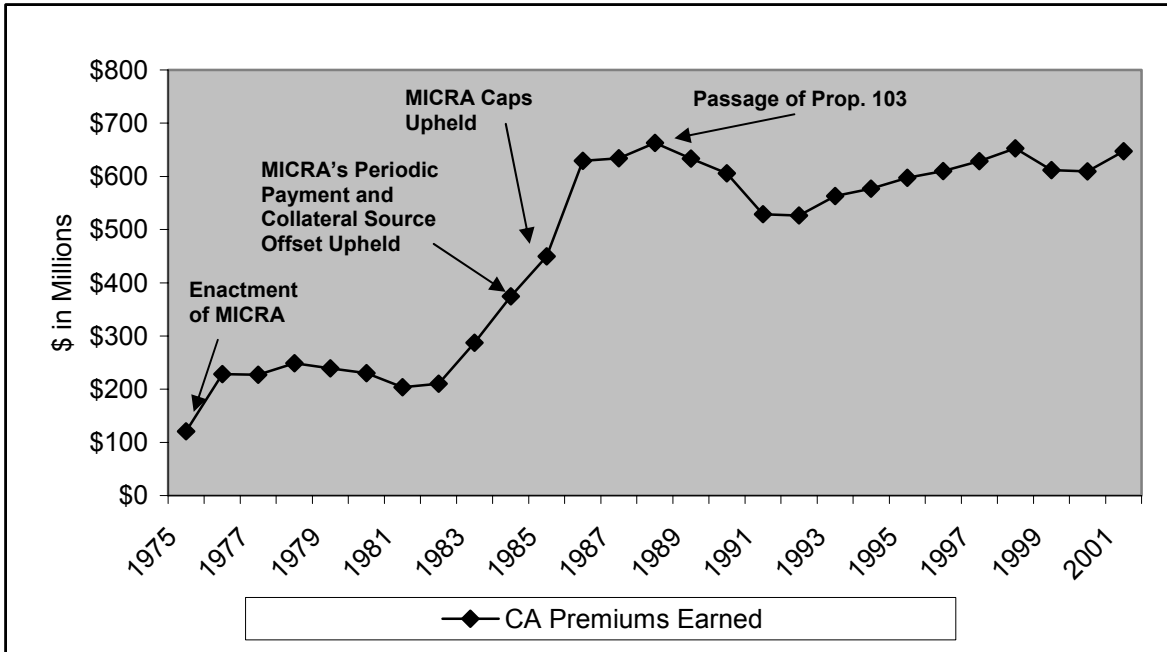
Ironically, the California experience exemplifies the success of insurance reforms, not the imposition of damage caps, at keeping malpractice rates lower. In a revolt against skyrocketing auto and homeowners insurance rates, voters passed Proposition 103 in 1988. This strong pro-consumer measure, which also applied to lines of medical malpractice insurance, instituted a 20 percent rate rollback and made it much more difficult for companies to get future rate increases.

The effect on medical-malpractice insurance premiums was staggering. In the first 12 years of MICRA (1976-1988) malpractice insurance premiums earned (paid) *increased* 190 percent, but under Prop 103 premiums earned *declined* 2 percent from 1988-2001.<sup>37</sup> [See Figure 23]

- **California premiums continued to rise after enactment of MICRA.** In 1976, the first year of MICRA, the total premiums earned by California insurers were \$228.5 million but by 1988 premiums had skyrocketed to \$663.2 million – a jump of 190 percent. Initially insurers argued that questions concerning the constitutionality of MICRA prevented the lowering of premiums. However, MICRA's constitutionality was upheld in State Supreme Court decisions handed down in 1984 (periodic payments and collateral source provisions upheld) and 1985 (damage cap upheld). Nevertheless, premiums earned saw their largest jump in 1986 than in any year since the adoption of MICRA despite the fact that insurance companies set premiums based on *what they expect that years' losses to be in the future*, not based on what happened in the past.
- **Medical malpractice premiums decreased after passage of Prop 103 in 1988.** In 1988, California voters, facing skyrocketing insurance premiums and angry at the failure of "tort reform" to deliver on its promise to reduce insurance rates, went to the ballot box and passed Prop 103 the nation's most stringent reform of the insurance industry's rates and practices. It was applicable to all lines of property-casualty insurance, including auto, homeowners, commercial and medical malpractice. Within three years of passage of Prop 103, medical malpractice premiums dropped 20 percent, and thereafter have generally followed the rate of inflation. Overall, since 1988 total premiums earned have decreased about 2 percent, dropping from \$663.2 million in 1988 to \$647.2 million in 2001.

Figure 23

California Medical Malpractice Premiums, 1975 - 2001



Source: The Foundation for Taxpayer and Consumer Rights, based on National Association of Insurance Commissioners' Reports on Profitability By Line By State, 1976-2001, Direct Premium Earned 1975. A.M. Best special data request.

**Reasons Prop 103 Has Been So Successful at Reducing Rates**

- **Prop 103 created a stringent disclosure and “prior approval” system of insurance regulation.** This requires insurance companies to submit applications for rate changes to the California Department of Insurance for review before they are approved. Prop 103 gives the California Insurance Commissioner the authority to place limits on an insurance company’s profits, expenses and projections of future losses (a critical area of abuse).
- **Prop 103 repealed anti-competitive laws in order to stimulate competition and establish a free market for insurance.** Prop 103 repealed the industry’s exemption from state antitrust laws, and prohibited anti-competitive insurance industry “ration organizations” from sharing price and marketing data among companies, and from projecting “advisory,” or future, rates, generic expenses and profits. It repealed the law that prohibited insurance agents/brokers from cutting their own commissions in order to give premium discounts to consumers. It permits banks and other financial institutions to offer insurance policies. And it authorizes individuals, clubs and other associations to unite to negotiate lower-cost group insurance policies.

- **Recent consumer challenge to medical malpractice insurance rate hike saves California doctors \$23 million.** California’s State Insurance Commissioner ruled in September 2003 that the second largest medical malpractice insurer’s rate request was excessive. The request was determined to be in violation of Prop 103 regulations. The Insurance Commissioner ordered medical malpractice insurer, SCPIE Indemnity, to slash its proposed rate increase for doctors by 36 percent after an eight-month regulatory investigation of the firm’s rate request. The Foundation for Taxpayer and Consumer Rights (FTCR), a California nonprofit, non-partisan organization that initiated the rate challenge called the ruling another tribute to the effectiveness of California’s insurance reform initiative known as Prop 103.

## Non-Economic Damage Awards Paid by Doctors in Texas Have Remained Constant

Caps on non-economic damages have been a priority of the medical lobby because it's politically easier to deny damages that aren't accompanied by an invoice or pay stub. However, it is clear from examinations of claims files that these damages are not "skyrocketing". In fact, they are barely growing at all.

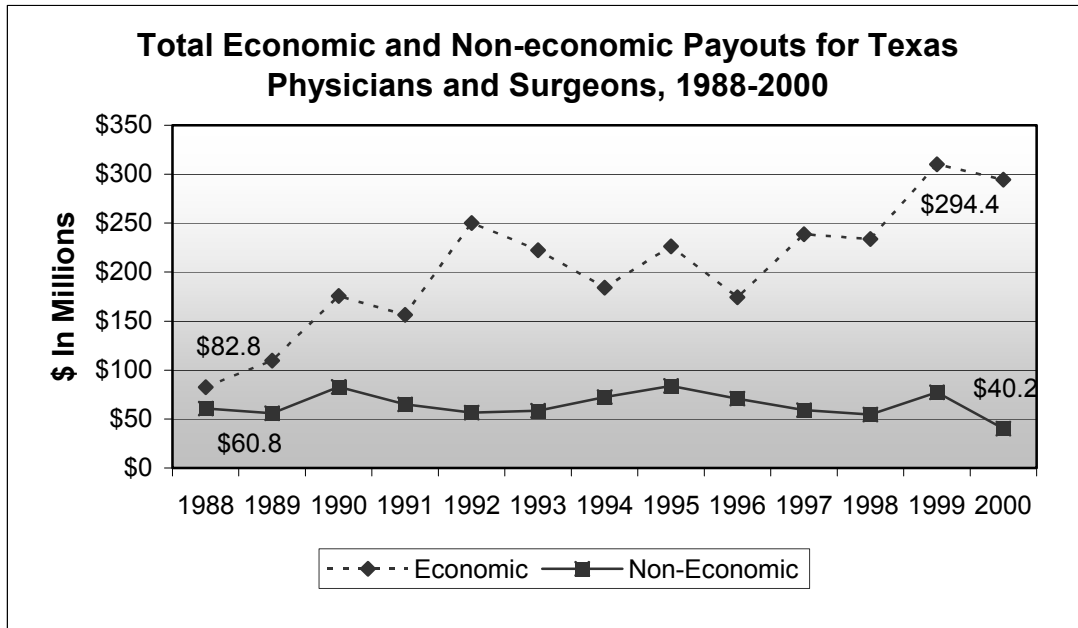
Little data exists about the amounts and percentages of total medical malpractice awards paid by doctors that go towards economic and non-economic damages. Florida and Texas may be the only two states that collect such information. A soon-to-be published study of Florida claims files, presented by Duke University researchers at a DePaul University Law School conference in April 2004, found that nearly all of the growth in awards over the past decade can be attributed to wage losses. In other words, as patients' incomes have grown, so have their losses when an injury disables them from work.

Texas law requires the Texas Department of Insurance to gather liability claims information from insurers, including the amounts of economic and non-economic damages payouts, and issue an annual report.

Texas Public Citizen analyzed 13 years of insurance company closed claims reports filed with the Texas Department of Insurance to determine payout trends in economic (lost income and medical care) vs. non-economic (pain and suffering due to injuries) damages.<sup>38</sup> The study found that increased payouts are due to a rapid acceleration in economic damages, not in non-economic damages. Thus, capping non-economic damages awarded to survivors of medical malpractice would do little, if anything, to stop the rise in the amount of overall malpractice payouts.

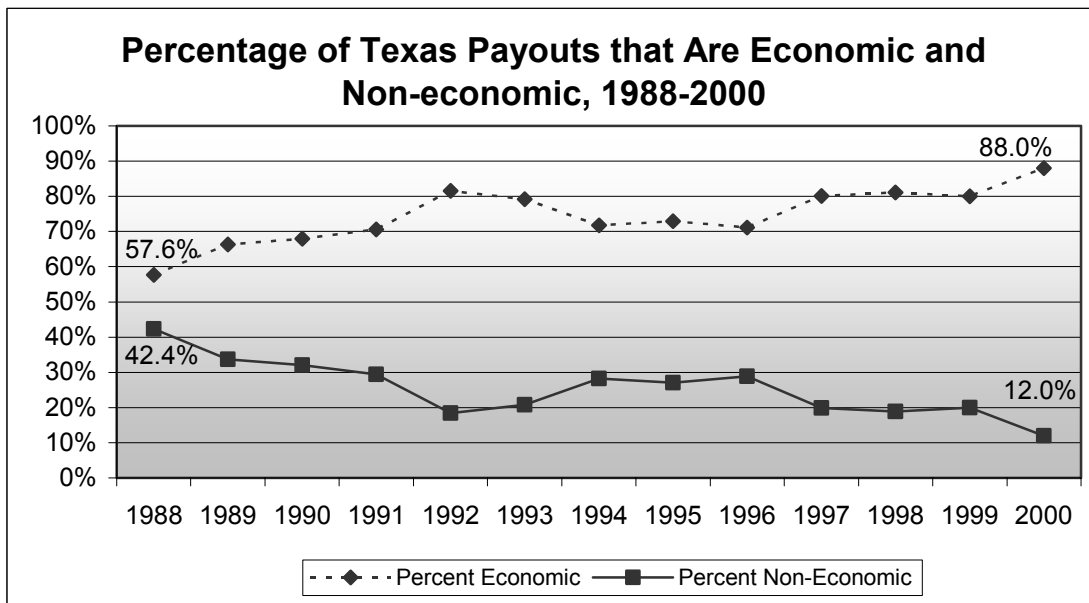
- **In Texas, economic damage awards in medical malpractice cases rose dramatically between 1988 and 2000 while non-economic damages declined.** In 1988, economic damage awards totaled \$82.8 million but had risen to \$294.4 million by 2000 – a 212 percent increase. Non-economic damage awards, however, totaled \$60.8 million in 1988 and declined to \$40.2 million in 2000 – a drop of 34 percent. [See Figure 24]
- **The non-economic percentage of the total yearly medical malpractice payout in Texas declined dramatically between 1988 and 2000.** In 1988, non-economic damages comprised 42.4 percent of the total amount of medical malpractice payouts made by doctors. However, the non-economic share dropped dramatically to 12 percent by 2000. In contrast, economic damages comprised 57.6 percent of all doctor payouts in 1988 but climbed to 88 percent by 2000. [See Figure 25]

**Figure 24**



Source: Texas Department of Insurance Closed Claims Data, 1988-2000.

**Figure 25**



Source: Texas Department of Insurance Closed Claims Data, 1988-2000.

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

Although the AMA and its ideological allies, like Oklahomans for Lawsuit Reform, adamantly insist that patient litigation has triggered a medical malpractice insurance “crisis,” government agencies and experts in the insurance field attribute rises in the cost of malpractice insurance to a decade of under-pricing by carriers and a downturn in the U.S. economy since 2000. Recent industry profitability reports show the property/casualty insurance industry, of which medical liability is one line of business, to be on the rebound.

- **U.S. property/casualty insurers’ profits increased nearly 900 percent in 2003.** U.S. property/casualty insurers’ profits surged to \$29.9 billion in 2003, which is an almost tenfold increase over the \$3.1 billion the insurers collectively reported in 2002, according to the Insurance Services Office Inc. and the Property Casualty Insurers Association of America. Net premiums written in the industry increased 9.8 percent, to \$405.9 billion. In addition, the industry’s statutory surplus increased 21.6 percent to \$347 billion at year-end 2003. These remarkable gains were achieved in spite of catastrophe losses that more than doubled in 2003.<sup>39</sup>
- **U.S. property/casualty insurers’ return on equity is likely to soar in 2004.** According to the Insurance Information Institute, return on equity in 2004 is likely to soar above double digits for the first time since 1997 because underwriting performance is expected to continue to improve and the investment environment should allow for the realization of significant capital gains as well as higher investment yields on the industry’s bond portfolio.<sup>40</sup>
- **Congressional Budget Office links rising premiums to insurance company investment losses.** In January 2004, the Congressional Budget Office noted that the 15 biggest medical malpractice insurers saw their investment returns drop by 1.6 percent from 2000 through 2002. “That figure corresponds to almost half of the 15 percent increase in [medical malpractice premium] rates estimated by the Centers for Medicare and Medicaid Services,” the CBO reported.<sup>41</sup>
- **For much of the 1990s, doctors benefited from artificially lower premiums.** According to the International Risk Management Institute (IRMI), one of the leading analysts of commercial insurance issues, “What is happening to the market for medical malpractice insurance in 2001 is a direct result of trends and events present since the mid to late 1990s. Throughout the 1990s, and reaching a peak around 1997 and 1998, insurers were on a quest for market share, that is, they were driven more by the amount of premium they could book rather than the adequacy of premiums to pay losses. In large part this emphasis on market share was driven by a desire to accumulate large amounts of capital with which to turn into investment income.” IRMI also noted: “Clearly a business cannot continue operating in that fashion indefinitely.”<sup>42</sup>

- **PLICO admits it sold medical malpractice policies at rates “less than deemed appropriate or sound” in order to maintain market share.** In December 1998, Medical Protective Insurance Co. (MedPro), the chief competitor to PLICO in Oklahoma, successfully bid for University Hospital and other physician groups. MedPro offered medical malpractice coverage at rates lower than actuaries deemed appropriate. Still, in order to compete for a January 1999 renewal of these policies, PLICO elected to match MedPro’s bargain rates. As a result, PLICO’s direct premiums decreased by nearly 27 percent – counting its loss of market share (about \$5 million) and reduced revenue from premiums (almost \$8 million).<sup>43</sup> On April 6, 2004, the Oklahoma Insurance Commissioner approved a MedPro request for a 105 percent premium increase, confirming PLICO’s initial judgment that MedPro’s rates were too low.<sup>44</sup>
- **Medical liability premiums track investment results.** J. Robert Hunter, one of the country’s most knowledgeable insurance actuaries and director of insurance for the Consumer Federation of America, recently analyzed the growth in medical liability premiums.<sup>45</sup> He found that premiums charged do not track losses paid, but instead rise and fall in concert with the state of the economy. When the economy is booming and investment returns are high, companies maintain premiums at modest levels; however, when the economy falters and interest rates fall, companies increase premiums in response.
- **The same trends are present in other lines of insurance.** Property/casualty refers to a large group of liability lines of insurance (30 in total) including medical malpractice, homeowners, commercial, and automobile. The property/casualty insurance industry has exhibited cyclical behavior for many years, as far back as the 1920s. These cycles are characterized by periods of rising rates leading to increased profitability. Following a period of solid but not spectacular rates of return, the industry enters a down phase where prices soften, supply of the insurance product becomes plentiful, and, eventually, profitability diminishes, or vanishes completely. In the down phase of the cycle, as results deteriorate, the basic ability of insurance companies to underwrite new business or, for some companies even to renew some existing policies, can be impaired. This is because the capital needed to support the underwriting of risk has been depleted through losses.

The current market began to harden in 2001, following an unusually prolonged period of soft market conditions in the property-casualty section in the 1990s. The current hard market is unusual in that many lines of insurance are affected at the same time, including medical malpractice. As a result, premiums are rising for most types of insurance. The increases have taken policyholders by surprise given that they came after several years of relatively flat to decreasing prices.<sup>46</sup>

- **Insurer mismanagement compounded the problems.** Compounding the impact of the cycle has been misleading accounting practices. As the *Wall Street Journal* found in a front page investigative story on June 24, 2002, “[A] price war that began in the early 1990s led insurers to sell malpractice coverage to obstetrician-gynecologists at rates that proved inadequate to cover claims. Some of these carriers had rushed into malpractice coverage because an accounting practice widely used in the industry made the area seem more

profitable in the early 1990s than it really was. A decade of short-sighted price slashing led to industry losses of nearly \$3 billion last year.”<sup>47</sup> Moreover, “In at least one case, aggressive pricing allegedly crossed the line into fraud.” According to Donald J. Zuk, chief executive of SCPIE Holdings Inc., a leading malpractice insurer in California, “Regardless of the level of ... tort reform, the fact remains that if insurance policies are consistently under-priced, the insurer will lose money.”<sup>48</sup>

- **West Virginia Insurance Commissioner blames the market.** According to the Office of the West Virginia Insurance Commission (one of the states battered by a so-called medical malpractice “crisis” in 2002 and 2003), “[T]he insurance industry is cyclical and necessarily competitive. We have witnessed these cycles in the Medical Malpractice line in the mid-'70's, the mid-80's and the present situation. This particular cycle is, perhaps, worse than previous cycles as it was delayed by a booming economy in the '90's and is now experiencing not just a shortfall in rates due to competition, but a subdued economy, lower interest rates and investment yields, the withdrawal of a major medical malpractice writer and a strong hardening of the reinsurance market. Rates will, at some point, reach an acceptable level to insurers and capital will once again flow into the Medical Malpractice market.”<sup>49</sup>
- **Missouri Insurance Director says “tort reform” won’t relieve financial pressure on doctors.** In a February 2003 report on medical malpractice insurance, the director of Missouri’s Department of Insurance concluded that “further ‘tort reforms’ will not provide relief to financially distressed physicians for several years, if at all.” His report also found that “[p]hysicians are hard-pressed to absorb increased malpractice insurance costs when they have limited ability to pass on those expenses to managed care companies and government programs.”<sup>50</sup>
- **Financial analysts recognize the true cause of premium spikes.** Weiss Ratings, the “leading independent provider of ratings and analyses of financial services companies, mutual funds, and stocks,” reports that, “Tort reform has failed to address the problem of surging medical malpractice premiums, despite the fact that insurers have benefited from a slowdown in the growth of claims... The escalating medical malpractice crisis will not be resolved until the industry and regulators address the other, apparently more powerful, factors driving premiums higher.”<sup>51</sup> According to Weiss, six factors driving increases in medical malpractice rates are:
  - **Medical cost inflation.** Medical costs have risen 75 percent since 1991.
  - **The cyclical nature of the insurance market.** In an attempt to catch up, insurers have tightened underwriting standards and raised premiums.
  - **The need to shore up reserves for policies in force.** The only way to shore up reserves is to increase premiums.
  - **A decline in investment income:** This is particularly critical for lines of business like medical malpractice, in which the duration of claims payouts typically spans several years.
  - **Financial safety:** To restore their financial health, many medical malpractice insurers will remain under pressure to increase rates.

- **The supply and demand for coverage:** The number of medical malpractice carriers increased nationally through 1997 to 274, but has since fallen to 247 in 2002.
- **The American Medical Association acknowledges that spikes in malpractice premiums are caused by insurance cycles.** In a report by the AMA's Board of Trustees to its House of Delegates, the following statements acknowledged that increasing malpractice insurance premiums were linked to the insurance underwriting cycle:

“The insurance underwriting cycle is now at a point where insurers have both pricing power and a need to increase revenues through premiums as returns on investments are no longer able to subsidize underwriting loses [sic] and as insurers have suffered large claims losses in other areas.”<sup>52</sup>

“For several years, insurers kept prices artificially low while competing for market share and new revenue to invest in a booming stock market. As the bull market surged, investments by these historically conservative insurers rose to 10.6 percent in 1999, up from a more typical 3 percent in 1992. With the market now in a slump, the insurers can no longer use investment gains to subsidize low rates. The industry reported realized capital gains of \$381 million last year, down 30 percent from the high point in 1998, according to the A.M. Best Company, one of the most comprehensive sources of insurance industry data.”<sup>53</sup>

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

Caps on damages for pain and suffering will significantly lower the awards paid to catastrophically injured patients. But because such truly severe cases make up a small percentage of medical malpractice claims, and because the portion of the medical liability premium dollar that pays for compensation is dwarfed by the portion that pays for defense lawyer fees, caps do not lead to lower premiums. Insurance companies and their lobbyists understand this.

## **Premium on the Truth:**

“Insurers never promised that tort reform would achieve specific savings.” – American Insurance Association<sup>54</sup>

“We wouldn't tell you or anyone that the reason to pass tort reform would be to reduce insurance rates.” – Sherman Joyce, president of the American Tort Reform Association<sup>55</sup>

“Many tort reform advocates do not contend that restricting litigation will lower insurance rates, and I've never said that in 30 years.” – Victor Schwartz, general counsel to the American Tort Reform Association<sup>56</sup>

## **California**

“I don't like to hear insurance-company executives say it's the tort [injury- law] system – it's self-inflicted,” – Donald J. Zuk, chief executive of Scpie Holdings Inc., a leading malpractice insurer in California.<sup>57</sup>

## **Florida**

“No responsible insurer can cut its rates after a bill (that caps damages at \$250,000) passes.” – Bob White, president of First Professionals Insurance Co. (formerly Florida Physicians Insurance Company, Inc). The company is the largest medical malpractice insurer in Florida and has close ties to the Florida Medical Association.<sup>58</sup>

## **Illinois**

“There's a real question as to whether a cap on damages has a relationship to premiums ... There doesn't seem to be a lot of evidence that supports a correlation between caps and premiums.” – Leo Jordan, retired vice president and counsel for Illinois-based State Farm Insurance Companies and past chair of the American Bar Association's Tort Trial and Insurance Practice Section.<sup>59</sup>

## **Mississippi**

“Regardless of what may result from the ongoing tort reform debate, please remember that such proposed public policy changes are critical for the long-term, but do not provide a magical 'silver-bullet' that will immediately affect medical malpractice insurance rates ... The 2003 rate

change [a 45 percent increase] would happen regardless of the special session outcome.” – Medical Assurance Company of Mississippi<sup>60</sup>

### **Nevada**

“The primary insurer for Las Vegas obstetricians, American Physicians Assurance, has no plans to lower premiums for several years, if ever, said broker Dennis Coffin.” – Coffin is the Account Representative for SCW Agency Group – Nevada, which represents the American Physicians Assurance Corp.<sup>61</sup>

“[John Cotton of the Nevada Physicians’ Task Force] noted that even if the bill reflected a cap of \$5, there would not be an immediate impact on premiums.” – Minutes of the Nevada Assembly Committee on Medical Malpractice Issues<sup>62</sup>

### **New Jersey**

During a hearing on medical malpractice issues, New Jersey Assemblyman Paul D’Amato asked Patricia Costante, Chairwoman and CEO of MIIX Group of Companies, “[A]re you telling the insured physicians in New Jersey that if this State Legislature passes caps that you’ll guarantee that you won’t raise your premiums, in fact, you’ll reduce them?” Costante replied: “No, I’m not telling you [or them] that.”<sup>63</sup>

Financial analysis shows malpractice award “caps” would have little impact on the premiums doctors pay. In an analysis requested by the Medical Society of New Jersey, actuaries estimate that a “cap” on non-economic damages in malpractice cases would have only a slight impact on the amount doctors pay in liability premiums. “We would expect a \$250,000 cap on non-economic damages would produce some savings, perhaps in the 5 percent to 7 percent range,” the firm of Tillinghast-Towers Perrin reports. “A cap of \$500,000 is likely to be of very little benefit to physicians.”<sup>64</sup>

### **Ohio**

“In the short run, we may even see prices go up another 20 percent, and people will say, ‘Gee, what happened, I thought we addressed this?’” – Ray Mazzotta, president of Columbus-based Ohio Hospital Insurance Co.<sup>65</sup>

“The stroke of the governor’s pen [enacting caps on damages] will not result in immediate lowering of rates by responsible companies.” – Frank O’Neil, spokesman for Birmingham, Ala.-based Medical Assurance<sup>66</sup>

### **Wyoming**

During a hearing on medical malpractice insurance issues, Bruce Crile of the Doctors’ Company and Melissa Dennison of OHIC Insurance Company testified that insurance rates would not drop if caps on damages were imposed. “Both the Doctors’ Company and OHIC’s actuaries say a cap of \$500,000 is meaningless for purposes of ratemaking. Even with caps enacted premiums will still increase, but with predictability of the risk there will be a moderating of rate increases.” – Minutes of the Wyoming Legislature’s Joint Labor, Health and Social Services Interim Committee<sup>67</sup>

## Few Malpractice Lawsuits Are “Frivolous”

Proponents of tort limits in Oklahoma have claimed that medical liability insurance will become affordable only if the state takes action against so-called “abusive” lawsuits filed by patients.<sup>68</sup> Some Washington, D.C., politicians have made similar comments about “frivolous lawsuits” and “junk lawsuits” in their efforts to promote a federal medical malpractice bill that would place caps on pain-and-suffering awards to injured patients.<sup>69</sup>

In reality, medical malpractice cases are brought on a contingency fee basis, meaning the attorney receives payment only in the event there is a settlement or verdict. If the claim is closed without payment, the attorney does not receive a fee. Since attorneys must earn money to stay in business, it follows that they would not intentionally take on a non-meritorious case.

- **The high cost of preparing a medical malpractice case discourages frivolous claims – and meritorious claims as well.** Medical malpractice cases are very expensive for plaintiffs’ attorneys to bring, with out-of-pocket costs for cases settled at or near the time of trial (when most cases are settled) ranging from \$15,000 to \$25,000.<sup>70</sup> If the case goes to trial, the costs can easily be doubled.<sup>71</sup> These costs do not include the plaintiff’s attorney’s time, and an attorney pursuing a frivolous case incurs opportunity costs in not pursuing other cases. An attorney incurs expenses beginning with the determination of whether a case has merit. First, the attorney is required to obtain copies of the patient’s medical records from all the providers for analysis by a competent medically trained person. If that initial consultation reveals a likelihood of medical negligence, the records must then be submitted to medical specialists, qualified to testify in court, for final review. Typically, the records must be sent to experts outside of the plaintiff’s state, as physicians within the state will refuse to testify against local colleagues. As a result, the experts who agree to review records and testify can and do charge substantial fees. Fees from \$1,000 per hour to several thousand dollars are not uncommon.<sup>72</sup> Discovery involves taking the sworn testimony of witnesses and experts. Such depositions cost \$300 and up, depending upon their length and complexity. If an expert witness is deposed, the plaintiff’s attorney is charged for the witness’ preparation time and time attending the deposition.
- **The small numbers of claims pursued to a defense verdict are not frivolous.** Researchers at the American Society of Anesthesiologists arranged for pairs of doctors to review 103 randomly selected medical negligence claims files.<sup>73</sup> The doctors were asked to judge whether the anesthesiologist in question had acted reasonably and prudently. The doctors only agreed on the appropriateness of care in 62 percent of the cases; they disagreed in 38 percent of cases. The researchers concluded, “These observations indicate that neutral experts (the reviews were conducted in a situation that did not involve advocacy or financial compensation) commonly disagree in their assessments when using the accepted standard of reasonable and prudent care.” The percentage of all medical malpractice claims that go to trial is only 6.6 percent, according to PIAA, meaning that the parties and their attorneys ultimately reach agreement about liability five times more often than neutral doctors do. If

truly frivolous lawsuits were being pursued, the proportion of claims going to trial would exceed the 38 percent of claims on which even doctors will disagree.

- **The costs of defending claims that are ultimately dropped are not unreasonable.** Medical liability insurers have complained about the costs of defending cases that are ultimately dropped. But the professional obligation of lawyers to exercise due diligence is essentially identical to the duty of physicians. The lawyer must rule out the possibility of proving medical negligence before terminating a claim, just as doctors must rule out the possibility of illnesses suggested by their patients' symptoms. The doctor performs his duty by administering tests; the lawyer performs hers by using discovery procedures. Both processes can lead to dead ends. But plaintiffs' lawyers have no financial incentive to abuse the litigation process: they are using their own time and money to pursue discovery activities, and are only paid for work on behalf of clients whose cases are successful.

## End Notes

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- <sup>1</sup> Randy Krehbiel, “News Analysis: Tort Reform High on Agenda,” *Tulsa World*, Jan. 25, 2004.
- <sup>2</sup> E-mail from Lynn Means, public information officer, Oklahoma State Medical Association, to Public Citizen, April 20, 2004.
- <sup>3</sup> Presentation by PLICO to the Governor's Special Tort Reform Committee, March 26, 2003.
- <sup>4</sup> Carmel Perez Synder, “Polls Show Public Supports Tort Reform but Isn't Too Interested,” *The Daily Oklahoman*, Feb. 25, 2004.
- <sup>5</sup> Don Mecoy, “Chambers Urged to Join Efforts for Tort Reform,” *The Daily Oklahoman*, Feb. 13, 2004.
- <sup>6</sup> “Annual Percent Change in the Revised and Rebased Medicare Economic Index, 2004 – Cost Categories and Price Measures,” Centers for Medicare and Medicaid Services, *Federal Register*, vol. 68, No. 216, Nov. 7, 2003.
- <sup>7</sup> *Id.* The federal government indexes the average malpractice insurance cost nationwide at 3.86 percent of a doctor's practice income. For Oklahoma, it assigns a local malpractice cost value of .444, indicating Oklahoma doctors pay 44.4 percent of the national average in malpractice insurance costs. The 1.7 percent statistic for Oklahoma is calculated by multiplying these two numbers.
- <sup>8</sup> Katharine Levit, Cynthia Smith, Cathy Cowan, Art Sensenig, Aaron Catlin and the Health Accounts Team, National Health Statistics Group, Office of the Actuary, Centers for Medicare and Medicaid Services, “Health Spending Rebound Continues in 2002,” *Health Affairs*, Vol. 23, No. 1, January-February 2004.
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- <sup>10</sup> Jon Brock, “Medical liability reform will need creative approach,” *Tulsa World*, February 25, 2004.
- <sup>11</sup> Jim Copland, “Tort law represents a growth industry,” *The Daily Oklahoman*, March 2, 2004.
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- <sup>17</sup> Jim Stafford, “State ranks 3<sup>rd</sup> as ‘Pro-Business,’” *The Daily Oklahoman*, November 25, 2003.
- <sup>18</sup> Harvard Medical Practice Study Group, *Patients, Doctors and Lawyers: Medical Injury, Malpractice Litigation, and Patient Compensation in New York*, 1990.
- <sup>19</sup> Studdert et al, “Beyond Dead Reckoning: Measures of Medical Injury Burden, Malpractice Litigation, and Alternative Compensation Models from Utah and Colorado,” 33 *Ind. L. Rev.* 1643 (2000).
- <sup>20</sup> The Agency for Health Care Administration; Division of Health Quality Assurance, “Reported Malpractice Claims by District Compared to Reported Adverse Incidents 1996, 1997, 1998, 1999.”
- <sup>21</sup> Congressional Budget Office, Cost Estimate for H.R. 5, HEALTH Act of 2003, ordered by the House Committee on the Judiciary, submitted March 10, 2003.
- <sup>22</sup> United States General Accounting Office, Report GAO-03-836, “Medical Malpractice: Implications of Rising Premiums on Access to Health Care,” p. 27, August 2003. Available on-line at: <http://www.gao.gov/new.items/d03836.pdf>.
- <sup>23</sup> *Id.*, p. 29.
- <sup>24</sup> Chassin & Becher, “The Wrong Patient,” 136 *Ann Intern Med.* 826, 2002.
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- <sup>38</sup> Closed Claims Data for 1988 through 2000 were downloaded from the Texas Department of Insurance Web site. Available at <http://www.tdi.state.tx.us/index.html>. Field Q7C of this data indicates the business class associated with each claim. For this analysis, claims identified under the business class of "Physicians and Surgeons" (19) were used. If the payout is reached by settlements or verdict (either before or after a verdict) the insurance company is required to indicate in the closed claims survey whether or not the settlement was influenced by non-economic or exemplary damages. This information is indicated in either field Q11D2 or Q11E2. If either of these questions is answered in the affirmative, a breakdown of the settlement by damage category is provided. Where a claim was reportedly influenced by non-economic damages and no amount was attributed to non-economic or exemplary damages, an average non-economic and exemplary percentage was applied to the settlement amount (typically 30 percent and 10 percent, though they varied by year), so as not to underestimate the total amount under these categories. This occurred in only 36 out of 10,166 cases, and had a negligible effect on the outcome of the data analysis.
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- <sup>52</sup> American Medical Association Report 35 of the Board of Trustees, at <http://www.ama-assn.org/ama1/upload/mm/annual02/bot35a02.rtf>.
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<sup>67</sup> Testimony at the Wyoming Legislature's Joint Labor, Health and Social Services Interim Committee, Dec. 4-6, 2002.

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<sup>69</sup> "Remarks by the President on Medical Liability Reform," University of Scranton, Scranton, Pa., Jan. 16, 2003.

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<sup>70</sup> Based on Public Citizen interviews with plaintiff attorneys.

<sup>71</sup> N. Vidmar, *Medical Malpractice and the American Jury*, 1995.

<sup>72</sup> According to the Physician Insurers Association of America, expert witnesses in a medical malpractice case are paid on average over \$4,800.

<sup>73</sup> Posner et al, "Variation in Expert Opinion in Medical Malpractice Review," 85 *Anesthesiology* 1049, 1996.