Task Force Meeting Attendance Sheet

Medical Malpractice Task Force

Date: 9/8/05 **Meeting Type:** Public Hearing

Location: 412 East State Capitol

Committee Member	Present	Absent	Excused
Representative Curtis Gielow, Chair	☑	☐	☐
Representative Mike Huebsch	☑	☐	☐
Representative Ann Nischke	☑	☐	☐
Representative Jason Fields	☑	☐	☐
Representative Bob Ziegelbauer	☑	☐	☐
Mr. David Strifling	☑	☐	☐
Ms. Mary Wolverton	☐	☐	☑
Dr. Clyde "Bud" Chumbley	☑	☐	☐
Mr. David Olson	☑	☐	☐
Mr. Ralph Topinka	☑	☐	☐
Totals:	9	∅	1

Julie Sawyer
Task Force Clerk

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Cont. Pt. 2

P I C   W I S C O N S I N

Insurance Products • Risk Management Solutions

Testimony of PIC Wisconsin to the Medical Malpractice Task Force

September 8, 2005

September 8, 2005

TO: Medical Malpractice Task Force

FROM: Andrew Ravenscroft, VP of Operations and Mark Adams, Legal Counsel

RE: Medical Liability Insurance

Chairman Gielow and members, my name is Mark Adams and with me is Andrew Ravenscroft. In preparation for this hearing, we thought it would be helpful to provide the Task Force with an overview of the origins of our company, the factors driving our industry, how we set rates for insurance risk, and the impact of the Ferdon decision on rates for medical professional liability insurance.

For the Task Force's information, we've provided a copy of the full ECONorthwest July 2004 study on the effects in Oregon when a $500,000 noneconomic damage cap was overturned by its Supreme Court in 1999; plus, our appellant brief filed Sept. 1, 2005 in the Zak case, No. 04AP2698, where we provide previous court decisions indicating the inequity in applying retroactively a change in law, such as the Ferdon decision; and, a copy of the Aug. 31, 2005 Court of Appeals decision in the Kaul case No. 2004AP849, which the Court said will not be published. Of note, the Court of Appeals reversed, per the Ferdon decision, the trial court's reduction of the noneconomic damages awarded by a jury verdict rendered Nov. 18, 2002. Please see footnote 10 of the decision for the court's rationale.

Now, Andrew Ravenscroft will continue with our testimony.

Good morning. I'm Andrew Ravenscroft, VP Operations for PIC Wisconsin. We should note from the outset that while our testimony draws on some national statistics, we cannot claim to represent the entire medical professional liability industry but offer our own perspective as a Wisconsin-domiciled insurer on how we operate.

Our written document provides a more detailed discussion of our business and the medical professional liability marketplace and I will provide a brief high level summary of the main topics, which are:

- PIC mission, history, current status
- How risks are priced
- The "long tail"
- Rate setting
- Wisconsin rate stability
- The impact of the removal of the caps
- Will rates go up?

PIC mission, history, current status
PIC Wisconsin was formed in 1986 through the efforts of the State Medical Society of Wisconsin to address the problem of availability and affordability of Medical Professional Liability (MPL) insurance. While we also insure hospitals and dentists, for ease of reading I shall refer through this testimony to the range of healthcare coverage we offer as MPL.

The company was formed as a stock company and capitalized through the purchase of stock by policyholders as well as capital from other physicians' insurance companies. We are primarily owned and governed by Wisconsin healthcare professionals. Our 12 member Board of Directors has 7 actively-practicing Wisconsin physicians as members.

The original and continuing primary mission of the company has been to provide a stable and affordable MPL market for healthcare professionals in the state of Wisconsin.

The company now operates in 8 states and primarily provides medical, dental, hospital and corporate professional liability insurance. Approximately half of our written premium is in the state of Wisconsin.

How risks are priced
This explanation is intentionally simplistic and by no means definitive or exhaustive, and is intended to highlight the major issues in setting insurance rates. While there are other factors to consider, the intention here is not to provide a seminar on how to run an MPL insurance company, but to give the Task Force an appreciation of some of the issues that underlie the problem at hand.

At its simplest level insurance is about the transfer of risk. In exchange for financial consideration (the premium), the insurance company takes the risk on behalf of the insured. By pooling the risk and setting rates for individuals in the risk pool, the company is able to manage financial hazards that would be difficult for one individual to handle by themselves. This is especially useful where the individual is at risk for a high severity (i.e., high cost) event.

Two main factors are taken into account when setting premium rates for the risk to be transferred. These are the frequency of the insured event happening (in our case, how often a physician is likely to be sued), and the likely severity of the insured event (how much economic and non-economic damages the physician will be required to pay).

Relatively speaking, compared for instance to homeowner's insurance, our marketplace is characterized by low frequency, high severity events. By contrast, a homeowner's insurance company might get many more claims per insured but most of them will be low severity events.

The "long tail"
MPL is often referred to as a "long tail" line of business. What this means is that it may be years between the treatment that gives rise to a claim and the claim being filed. In addition, it will likely be years between the claim being filed with the insurance company and the final resolution of the claim. Presently our *average* time between the opening and closing of an individual claim in Wisconsin is approximately 3 years[1].

There are a number of reasons for this, and the main ones are:

- The patient's condition may only become apparent after time. For example, a patient may be diagnosed with cancer some years after having an x-ray slide taken. The radiologist that did the original slide reading may subsequently be sued for failure to diagnose
- The discovery and deposition process may take substantial time due to the availability of witnesses, and the fact that multiple individuals and businesses may be named in the suit
- The legal process itself can take time to go to trial, and subsequent appeals by either side in the dispute may stretch the process out even further.

The impact of the "long tail" is to introduce an unusual element of uncertainty into our line of insurance that isn't seen in most insurance types. For example, a property and casualty insurer that covers houses will know within a short time of the end of any given policy period whether or not any claims have arisen.

In our line of business we provide coverage for a physician knowing that we might get claims years from now that are based on something they did in their practice today.

Rate setting
This makes rate setting rather more complicated than in other lines of business. Any premium that we charge a physician today for an annual policy needs to include our best estimates of the value of all the future claims that may be filed against that physician (for incidents occurring during the policy period) until the statute of limitations runs out.

In essence rate setting works as follows. Actuaries use statistical information to try to predict the exposure represented by a given class of physician. They will run loss projections based on prior years of physician exposure to try to establish what the future losses are likely to be. This sounds simple enough, however it is complicated by a number of factors. Among these are:

- The availability of data. While in some instances the actuary may have access to a lot of information, in others (such as when the insurer enters a new state) they

[1] The Physician Insurers Association of America reported in its Data Sharing project 2002 that on average nationally MPL claims are reported to insurers 22 months after the incident date and are closed or paid an additional 33 months hence.

may have very little or be dependent on the rate and actuarial filings of other insurers.

- The complexity of the field being insured. Medicine is a highly complex affair, with many opportunities for things to go awry. Not only is the individual physician's judgment and medical skill and training a factor, but the healthcare infrastructure and administration within which they practice may affect outcomes.
- The continuing evolution of medicine. As medical technology evolves, new techniques, devices and drugs are being brought into play and there is the additional risk represented by the physician's familiarity with the new approach. The use of telemedicine and teleradiology (e.g., where x-ray slides are read via the internet) and other techniques for managing healthcare represent new exposures for the insurance company that are very difficult to assess. It may be years before we know the likely claim pattern arising from these exposures.
- Patient expectations. As advertising and marketing of medical services is aimed more and more at patients, the expectations that they have for medical outcomes may be unrealistic given the likely prognosis. Examples here might be unrealistic expectations for the outcome of cosmetic surgery. Another good example is bariatric surgery (gastric bypass surgery) which seems to have both a relatively high mortality rate (see the above bullet point), and is accompanied by high patient expectations for the outcome.[2]

In addition, the actuary will have to consider the legal climate in the territory where the insured is working and the presence or otherwise of caps or other controlling factors in limiting potential losses. Essentially, the more predictability they have in expected future losses, the more confident they can be about their rate analysis. Where there is poor predictability, the rates are less likely to be accurate and the responsibly managed insurance company will need to take this into account when deciding what to charge (given that the losses could be enormous).

It is critical to understand that when we talk about 'losses', we are not just talking about actual payments of indemnity to plaintiffs, but the costs of defending against claims that are either dropped or found in our defendant's favor at trial. *In a typical year PIC Wisconsin spends as much on defense costs as it does on indemnity payments.* Facts like these are often forgotten when people look at insurance company losses.

As well as the expected future loss experience, the company will add to the rates its operating expenses and a provision for profit. In this way a rate is built up that can be applied to individual physician specialties based on their expected exposure (an obstetrician, for example, will pay more than a family practice physician due to the increased likelihood of high severity claims).

It is important to note that, contrary to anecdote, the rates which are developed are specific to the territory under consideration. In other words, rates for Wisconsin are set

[2] See the attached PIC Wisconsin publication 'Key Considerations', Vol. 1, Issue 2, for more on the risks posed by bariatric surgery and our advice to insureds

using only Wisconsin loss experience and reflect the best assessment of the likely exposure represented by Wisconsin healthcare professionals.

In Wisconsin the rates along with all supplementary actuarial data are filed with the Office of the Commissioner of Insurance (OCI) and are public documents. Rate changes are filed annually, if there are any, and are carefully scrutinized by the OCI. Regulations in other states vary according to how the insurance department and statutes are structured, but usually involve a file and approve process.

Wisconsin rate stability

Amid the hyperbole about huge rate increases across the country, it is important to put Wisconsin in perspective. Wisconsin rates for MPL are among the lowest in the country, to the point where they attract physicians from not only neighboring states, but from across the country.

Also, Wisconsin rates have had a history of remaining relatively stable and increases over time have been gradual[3]. Further, in 5 of the last 6 years, PIC Wisconsin has paid a policyholder dividend to policyholder members of the Wisconsin Medical Society in recognition of their favorable loss experience.

Similarly, one might look at the rates we charge physicians in neighboring states for an indication of the relative differences in premium. The table below summarizes the current PIC Wisconsin rates for three major physician specialties in Wisconsin, Iowa and Illinois.

Physician Specialty	Illinois (territory 3, inc. Rockford)	Iowa	Wisconsin
Obstetrics/Gynecology	$108,378	$43,907	$32,255
Family Practice	$19,992	$6,272	$5,675
Family Practice with Obstetrics	$38,932	$13,939	$10,752

Table 1. Comparison of PIC Wisconsin premium rates by state. Premium shown is the mature claims made rate for $1M/$3M of coverage and includes no adjustments for individual loss experience.

It is our belief that this is a product of a combination of factors that makes Wisconsin somewhat unique. While many states look for a silver bullet that will 'fix' their MPL rate problems, this is a very complex situation and no one answer will take care of it.

Here in Wisconsin, we ascribe the relative rate stability to the presence of tort reform (including among other things the caps on non-economic damages), the Injured

[3] See Physicians and Surgeons Professional Liability – Historical Rate Changes, in the attachments.

Patients and Families Compensation Fund, WHCLIP, the quality of healthcare, Wisconsin "common sense" exercised by juries, a diligent OCI, and our own work as a healthcare professional-owned and governed Wisconsin MPL company. The removal or diminution of any one of these factors affects the overall picture.

Insurance company earnings and investments

The insurance industry is often characterized in the media by certain parties as being a high profit enterprise that makes risky gambles in the stock market and "gouges" its customers when it loses its shirt by backing the wrong horse.

Clearly this arises from a misconception as to how insurance companies operate and the place of the investment portfolio in managing risk.

In simple terms, the insurance company will use the spare cash generated from the gap between collecting premiums for coverage and the payment of claims to invest. This generates additional revenue that helps provide a buffer against unexpectedly high future losses (a real risk in our line of business) and an opportunity to defray the cost of insurance to the consumer (through reduced premiums based on the expectation of investment revenue).

The latter activity is one in which certain companies in the industry have had problems; usually because they did not have their eye on their likely long-term losses (their understanding of the MPL "long tail" was flawed). A number of large companies (such as Frontier) have gone out of business, and some (such as the St Paul Companies, once the writer of 8% of all MPL in the USA) have withdrawn from the marketplace.

With regard to the type of investments, the Physician Insurer's Association of America (PIAA), an association of companies like PIC Wisconsin, notes that MPL insurers on average are 80% invested in bonds and less than 10% invested in the stock market.

In an environment where we may experience serious unexpected losses it makes no sense to gamble on our long-term future. For our part, PIC Wisconsin's investment portfolio has an average triple A rating, meaning that for the most part (82% of the total investments) the money is invested in high quality, fixed income portfolios that include government and corporate bonds and the money market.

The quality of the investment portfolio is a significant factor in the maintenance of our AM Best rating. AM Best is an independent organization that provides financial strength and integrity ratings for the insurance industry. Great store is set by a company's AM Best rating, particularly by hospitals which may have debt covenants that do not allow them to be insured with an insurer that has less than an A rating.

PIC Wisconsin has maintained an "A- Excellent" rating with a stable outlook for the last 9 years, a rare accomplishment in an industry that has seen many competitors downgraded.

There is a further error in evaluating the profitability of insurance companies that is often made and is worth of note. Looking at any given year of operation it might be possible to say, for example, that an insurance company took in $10M in premiums but only paid out $5M in losses. *The problem with this argument is that the premium relates to future claims that may be reported to the company, the $5M relates to claims that happened in previous years.*

For a true comparison, we should look at the premium that the company took in during say, 2001, and the losses that related to that year's premium, i.e. we look back from the standpoint of 2008 and evaluate how the premium we charged back in 2001 stands up compared to all the losses we subsequently incurred *for that year.* This comparison is known as looking at the 'accident year', and is the tool primarily used by actuaries to determine likely future losses. Obviously, it is only really useful enough time has passed to allow you to see how your losses developed.

The impact of the removal of the caps

There is much debate nationally about whether the imposition of caps has an impact on the MPL insurance rates. Reams of studies have been written, most of them partisan from one side or another, about whether a cap on non-economic damages has any effect on what is charged to the policyholder.

We suggest that Wisconsin is in a different situation to the rest of the nation. In our case, a cap that has been in place for ten years has been removed, and the only really analogous environment we can point to is Oregon[4].

In states where caps have recently been imposed, for example the recent cap in Illinois, it is difficult to judge yet whether they will have the desired effect. Since the insurer's losses on today's policyholders extend far out into the future it is unwise to reduce rates until the caps have been tested and have withstood scrutiny by the Illinois Supreme Court. Once they are proven to have standing, all other factors being equal (for example no change in the frequency of claims), then rates in Illinois should go down.

In our case, our actuaries have been able to rely on the Wisconsin cap in setting their rates. Up until the Ferdon decision, we knew that our maximum exposure on any policyholder for non-economic damages was approximately $445,000 and we could set rates accordingly. Post-Ferdon, our exposure has increased from $445,000 to $1 million, at which point the Injured Patients and Families Compensation Fund takes over. At this point in time, we have additional exposure on existing policies with all of our 5,000-plus insured Wisconsin physicians for which we are not able to charge additional premium.

To suggest that the presence of caps, at least in the case of Wisconsin, has not helped keep premiums lower is clearly incorrect. In the environment in which we now operate, post-Ferdon, we not only have the exposure on current policyholders which has

[4] See EcoNorthwest study in the attachments

increased, but the very real potential that earlier cases in which judgment was rendered may be revisited[5].

Will rates go up?
The simple answer is: most likely, yes. However there is more to the picture than the simple exposure increase.

Clearly the exposure to the company has increased, and we need to charge for it. Anything else would be imprudent and could jeopardize the future of the company. The challenge before us is to determine what additional exposure we have to deal with and what we should charge for it.

This is not a simple matter. We know that in all likelihood will we face potential awards up to $1M for non-economic damages (an increase in severity), but that there may also be an increased frequency of claims that were not brought previously because of low economic value.

As already noted the task before us is to evaluate the likely future value of non-economic damage claims and build that into our rates. We are presently reviewing our previous claims history to try to build a picture of what that might look like so that we can file with the OCI if necessary for a rate increase.

In any case, our mission is to provide affordability and availability to the Wisconsin marketplace and we will not overreact to the situation. Any increase for 2006 is likely to be a modest one, and we will track how the loss experience develops over time. With the "long tail" nature of our product, however, we could find ourselves (as Oregon did) in a situation where a few years out from Ferdon we find that losses are worse than expected and we have to adjust for future exposure by taking significant increases in 2007 and beyond.

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[5] See Kaul case, No. 2004AP849, in the attachments

Attachments

- PIC Wisconsin Physicians and Surgeons Professional Liability – Historical Rate Changes
- ECONorthwest, July 2004 study
- Zak brief
- Kaul decision
- Trendwatch
- Professional Liability Newsletter
- Key Considerations – Bariatric Surgery

PHYSICIANS INSURANCE COMPANY OF WISCONSIN

STATE OF WISCONSIN

PHYSICIANS & SURGEONS PROFESSIONAL LIABILITY

HISTORICAL RATE CHANGES

Year	Effective Date	Rate Level Change	
1986	1/1/1986	0.00%	
1987	1/1/1987	0.00%	
1988	1/1/1988	13.10%	
1989	1/1/1989	11.70%	
1990	1/1/1990	0.00%	
1991	1/1/1991	-14.00%	
1992	1/1/1992	0.00%	
1993	1/1/1993	12.50%	
1994	1/1/1994	-5.00%	
1995	1/1/1995	-7.00%	
1996	1/1/1996	0.00%	
1997	1/1/1997	0.00%	
1998	1/1/1998	-10.00%	(1)
1999	1/1/1999	-2.80%	(2)
2000	1/1/2000	-8.60%	(3)
2001	1/1/2001	5.00%	(4)
2002	1/1/2002	7.00%	(5)
2003	1/1/2003	9.00%	(6)
2004	1/1/2004	9.40%	(7)
2005	1/1/2005	0.00%	

Notes:

(1) Base rates and class relativities were not changed.
Maximum loss-free credit increased from 7.5% to 10%.
Max group discount increased from 30% to 40%
5% MBP credit implemented effective 1/1/98.

(2) Base rates were not changed.
-2.8% change from relativity changes for selected specialties.

(3) Base rates were not changed.
-4.2% change from relativity changes for selected classes.
-4.6% change from increasing maximum loss-free discount from 10% to 15%.

(4) +5.0% rate increase from ILF increase @$1mill/$3mill (1.496 changed to 1.571).
Increased psychologist and mental health counselor rates, respectively, 17.6% and 19% (minimal overall rate level impact).
Added podiatrist rates.

(5) +3.0% rate increase from ILF increase @$1mill/$3mill (1.571 changed to 1.618).
+1.0% overall increase from selected specialty relativity changes:
- Radiology- Diagnostic (+25% increase in rate relativity)
- Psychiatry w/ECT (+25% increase in rate relativity)
- Class 3A specialties (+2.9% increase in rate relativity)
- OB/GYN (+4.9% increase in rate relativity)

+3.0% corporate coverage charge increase

(6) +8.5% overall manual rate level change:
- +9% base rate change
- Selected specialty relativity changes

Corporate coverage charge increased from 5% to 6% for non-MBP
- For MBP, corporate cov charge increased from 3% to 3.6%

(7) Base rate increase of +9.0% and selected relativity changes.

Medical Malpractice Damage Caps

Impacts of Limiting Noneconomic Damages

Prepared by Stephen Grover, Ph.D.

July 29, 2004

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Executive Summary

ECONorthwest was hired by the Oregon Medical Association (OMA) to evaluate the current state of medical malpractice liability in the State of Oregon. In particular, ECONorthwest was asked to provide a comprehensive, objective analysis of the impacts of capping payments for noneconomic damages. ECONorthwest has reviewed publicly available information as well as information provided by the OMA and insurance providers. Some of these data are confidential and proprietary.

The damages associated with a medical malpractice claim fall into two categories: economic damages that compensate for the monetary costs of an injury and noneconomic damages for items such as pain and suffering. The average physician in Oregon has had approximately one claim filed during his or her career. Approximately 20 percent of the claims filed in Oregon resulted in payment. While the number (claim frequency) has decreased by over 54 percent since the damage cap was imposed in 1987, the average payment (claim severity) has increased by 449 percent during the same period. While 20 years ago, payments of $1,000,000 or more constituted only 2 percent of paid claims, and 23 percent of the total dollars paid, in 2003, payments of $1,000,000 or more constituted 11 percent of paid claims and 52 percent of total dollars paid; or a 225 percent increase. The first quarter of 2004 continues this troubling trend where payments of $1,000,000 or more constituted 46 percent of the paid claims and over 85 percent of total dollars paid (see Figure 5). Since caps on non-economic damages were lifted following the Oregon Supreme Court's 1999 *Lakin v. Senco* decision, the average medical liability payment has grown by 90 percent from $247,000 to $470,000. Coincident with the growth in the amounts paid and the number of high-payout claims, medical malpractice premiums have grown by as much as 330 percent for some specialties (see Figure 2 and Figure 3).

From our research, we draw the following conclusions:

- **Oregon malpractice premiums and payments are well above the national average.** With an increase in malpractice premiums of 80 percent from 2001 to 2002, the U.S. department of Health and Human Services has identified Oregon as the state with the fourth-highest increase in premiums and the AMA has identified Oregon as one of 12 'crisis states'. Since 2000 (the year after the damage cap was lifted), Oregon's average payment on medical malpractice claims has risen well above the national average, while prior to 2000 the average malpractice payment in Oregon was consistently near the national average (see Figure 4).

- **Increasing medical malpractice premiums will ultimately reduce the number of physicians providing procedures that carry the higher premiums**. Increasing medical malpractice insurance rates have been associated with a declining number of physicians in Oregon, especially in rural areas and in those specialties experiencing the steepest premium increases. A 2002 OHSU survey of obstetrical clinicians in Oregon

showed that 34 percent of all those delivering babies have quit performing deliveries since 1999. Of these, 75 percent practice outside the Portland metropolitan area where more than one-half the state's women give birth. In addition, 31 percent of the obstetricians said they intended to quit deliveries within the next five years. An OMA survey of doctors within Oregon indicates that many are planning to or have stopped performing inherently high risk procedures and are considering retiring. Unless the situation changes, the current medical liability environment will discourage efforts to attract new physicians to the state.

- **Increasing claims payments account for nearly all of the increase in medical malpractice premiums**. Claims payments account for about two-thirds of insurers' total costs, and increase number of claims will increase overall insurance costs and ultimately increase premiums. Declining investment returns and reduced competition only account for a small portion of the increase in medical malpractice premiums both in Oregon and the nation.

- **Capping noneconomic damages would reduce medical malpractice premiums**. Evidence from Oregon's earlier experience and that of other states indicate that such limits reduce malpractice payments and, in turn, malpractice insurance premiums. Evidence in the literature also indicates that such limits can reduce health care costs.

Section I

Medical Malpractice Insurance In Oregon

Malpractice is defined as the failure to exercise that degree of care as is used by reasonably careful physicians in the same or similar community. This failure must be a substantially contributing cause of the injury.[1]

Generally, medical malpractice cases involve several stages: discovering the injury, loss, or damage; filing a claim; determining (through settlement or trial) payment responsibilities, if any; and paying the claim. The average physician in Oregon has had approximately one claim filed during his or her career.[2] The OMA estimates that only 20 percent of claims filed result in any payment.

The damages associated with a medical malpractice claim fall into two categories. *Economic damages* compensate a plaintiff for the monetary costs of an injury, such as medical bills or loss of income. *Noneconomic damages* are payable for items other than monetary losses, such as pain and suffering, loss of consortium, and loss of companionship. Punitive damages are a separate penalty (from economic and non-economic damages) that cannot be awarded unless there is proof by clear and convincing evidence that a health care provider acted with malice or reckless and outrageous indifference to an unreasonable risk of harm. There is a strong presumption that payments for pain and suffering are too high in the U.S. and that the resulting unpredictability of awards contributes to volatility in liability-insurance markets.[3] The Council of Economic Advisors (CEA) estimates that only 20 percent of the direct costs of torts actually go to claimants for economic damages such as lost wages or medical expenses.[4]

In Oregon, recent malpractice awards have had a substantial non-economic damage component. Of 15 plaintiff verdicts in Oregon malpractice cases from 1999-2002, economic damages totaled $9,670,677 while non-economic damages were $9,983,040, or 51 percent of the total damages awarded.[5]

Damage awards comprise only a fraction of the costs of liability. The CEA estimates that approximately 16 percent of tort costs are for defending claims.[6] The OMA calculated an average defense cost of $8,075 associated with a case closed without payment to the claimant. The defense costs of claims that result in

[1] ORS 677.095.

[2] Oregon Medical Association, Preliminary Report of the 2003 Physician Workforce Assessment, undated.

[3] Danzon, Patricia M., "Tort Reform: The Case of Medical Malpractice," *Oxford Review of Economic Policy*, March 1994.

[4] Council of Economic Advisors, *Who Pays for Tort Liability Claims? An Economic Analysis of the U.S. Tort Liability System*, April 2002.

[5] Gallagher, William J, Northwest Physicians Mutual Insurance Company, "Oregon Medical Liability Crisis", undated presentation.

[6] Council of Economic Advisors, *Who Pays for Tort Liability Claims? An Economic Analysis of the U.S. Tort Liability System*, April 2002.

payments are somewhat higher (average of $14,154) because of the added costs associated with the trial process. Cases in Oregon that are actually tried to verdict currently have average defense costs of more than $100,000.

Medical Malpractice Insurance

Most Oregon physicians not covered by hospital liability policies or employed by public entities but are served by one of two insurers: CNA or Northwest Physicians Mutual. Farmers Insurance was also a significant insurer for hospitals in the State but exited in 2003 because of declining profitability.

Medical malpractice insurers collect premiums from policyholders in exchange for an agreement to defend and pay future claims within the limits set by the policy. The insurer invests the premiums collected and income from the investments reduces the amount of premium income that would have been required otherwise. The insurer's expenses include claims against its policyholders as well as the insurer's estimates of future losses on those claims. The liability associated with the portion of incurred losses that have not yet been paid by the insurer is known as the insurer's *loss reserve*. Insurers must maintain assets in excess of total liabilities including loss reserves and reserves for premiums received but not yet earned. Together these make up what is known as the *insurer's surplus*. State insurance departments monitor insurers' solvency by tracking insurers' premiums, reserves, and surpluses.

Medical malpractice insurers generally attempt to keep their surplus approximately equal to their annual premium income. They set premium base rates for particular medical specialties within a state and sometimes for particular geographic regions within a state. They may also offer discounts or add surcharges for the particular characteristics of policyholders, such as claim histories or participation in risk management programs.[7] In Oregon, the Insurance Division of the Department of Consumer and Business Services has the authority to approve or deny proposed changes to premium rates and may hold a hearing for any rate increase or decrease greater than 15 percent.

Their small number and long and variable nature make losses on medical malpractice claims difficult to predict accurately. Nationally, most medical malpractice claims take an average of more than five years to resolve from the time the alleged malpractice is discovered through the payment of the claim (if any malpractice is found). Some claims may not be resolved for as long as 8 to 10 years. Oregon, on the other hand, has one of the shortest lags, on average 18-36 months, among the states between the time of incident and trial.[8]

The potential losses may vary widely because individual claims with similar characteristics can result in very different losses for the insurer. Because the pool

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[7] U.S. General Accounting Office, *Medical Malpractice Insurance: Multiple Factors Have Contributed to Increased Premium Rates*, GAO-03-702, June 2003.

[8] Wellington, Elizabeth A., *Loss Development Patterns in Medical Malpractice*, presentation, Casualty Actuarial Society, Seminar on Reinsurance, 2002.

of relevant policyholders is small, historical claims data is of little use in predicting future claims and payments, especially in a volatile market.[9]

Most physicians have policies that cover $1 million per claim and $3 million in aggregate.[10] On average, premiums for all physicians nationwide rose by 15 percent between 2000 and 2002. This increase was nearly twice as fast as total health care spending per person. The premium increases during that period were highest among obstetricians/gynecologists (22 percent) and internists and general surgeons (33 percent).[11]

Figure 1 shows the relative changes in premiums for CNA and Northwest Physicians Mutual. In this figure, we have indexed premium levels so that 1987=100 for both companies and changes in premium levels are more easily expressed as percentage changes. For example, a drop of 20 points in the graph corresponds to a 20 percent decrease in premiums. 1987 was chosen as the base year as this was the first year the damage cap was instituted in Oregon.

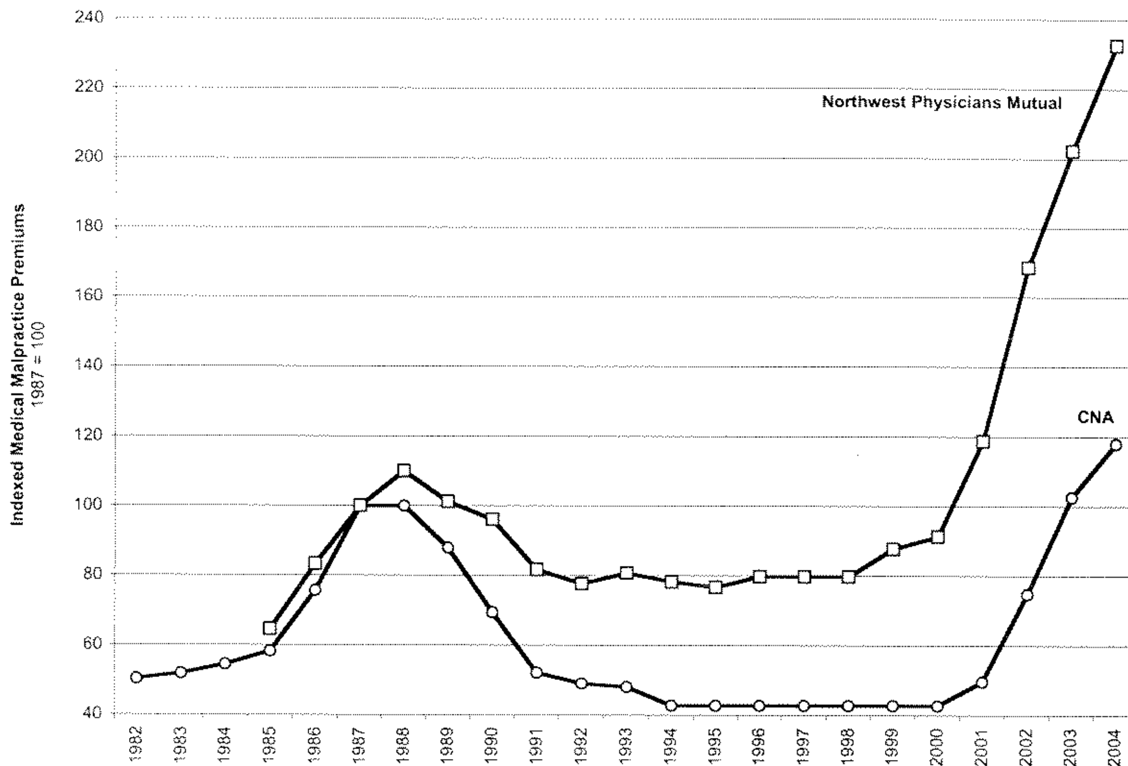
As shown in Figure 1, premiums for both companies decreased after 1987 and then remained relatively stable from 1991 to 1999. Following the lifting of the cap in 1999, premiums for both firms increased sharply. This large increase—particularly the 80 percent jump from 2001 to 2002—prompted the U.S. Department of Health and Human Services to identify Oregon as the state with the fourth-highest increase in medical malpractice premiums. The AMA has also designated Oregon as one of 12 "crisis states" due in part to high malpractice premiums.

[9] U.S. General Accounting Office, *Medical Malpractice Insurance: Multiple Factors Have Contributed to Increased Premium Rates*, GAO-03-702, June 2003.

[10] Oregon Medical Association, Preliminary Report of the 2003 Physician Workforce Assessment, undated; U.S. General Accounting Office, *Medical Malpractice: Implications of Rising Premiums on Access to Care*, GAO-03-836, August 2003.

[11] U.S. Congressional Budget Office, *Economic and Budget Issue Brief: Limiting Tort Liability for Medical Malpractice*, January 8, 2004.

Figure 1: Indexed Medical Malpractice Premiums for Oregon Physicians, 1982-2004 (1987=100)



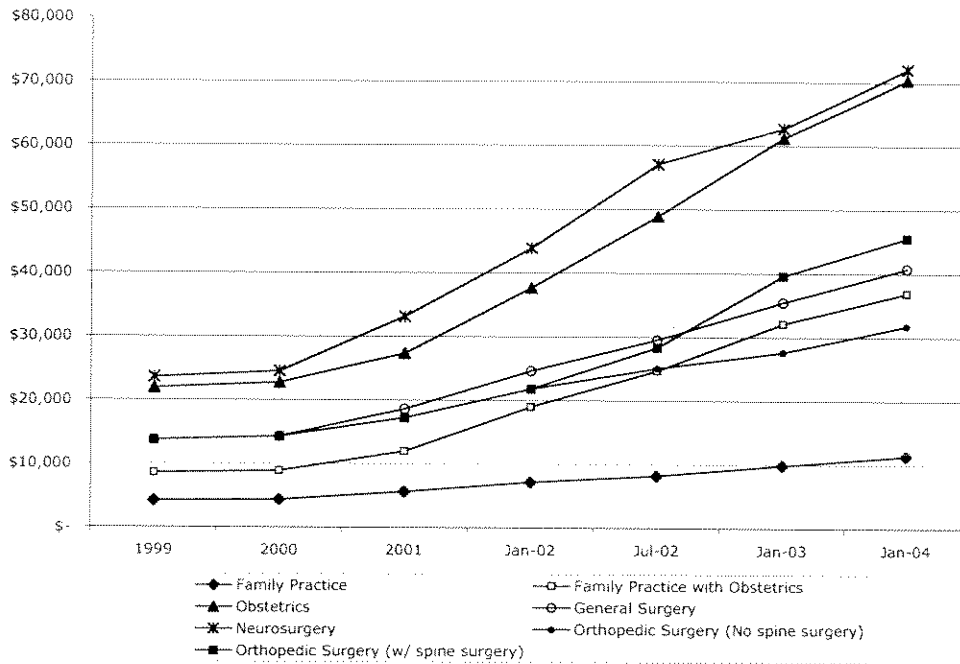
Source: CNA and Northwest Physicians Mutual

The following charts provide additional detail on premium increases for individual practice areas for both insurance companies. Figure 2 shows the premium rates for various practice areas from 1999 to 2004 for Northwest Physicians Mutual. The table below the figure shows the percentage increase in premiums over time for each specialty. For all specialty areas, premiums increased only 4 percent in 1999-2000, the first year in which the damage cap was lifted in Oregon. Since then, all practice areas have seen sharp increases in premiums.

For family practice (the practice area with the lowest malpractice premiums), Northwest Physician Mutual premiums have increased 172 percent from 1999 to 2004. Riskier practice areas such as obstetrics and neurosurgery have correspondingly higher premium levels. These areas have also experienced the sharpest increases in premiums since 1999. Neurosurgery, for example, has seen premiums increase by 206 percent from 1999 to 2004. Higher increases are also observed for those practice areas that also include one of the high-risk components. For family practice that includes obstetrics, for example, premiums have increased 332 percent from 1999 to 2004, compared to a 172 percent increase for family practitioners that do not cover obstetrics. Similarly, orthopedic surgeons who do spinal surgery have experienced a 231 percent

increase in premiums from 1999 to 2004. In contrast, orthopedic surgeons who do not cover spinal surgery have had lower premium increases of 131 percent over the same period.

Figure 2: Medical Malpractice Premium Levels and for Northwest Physicians Mutual (Selected Specialties)

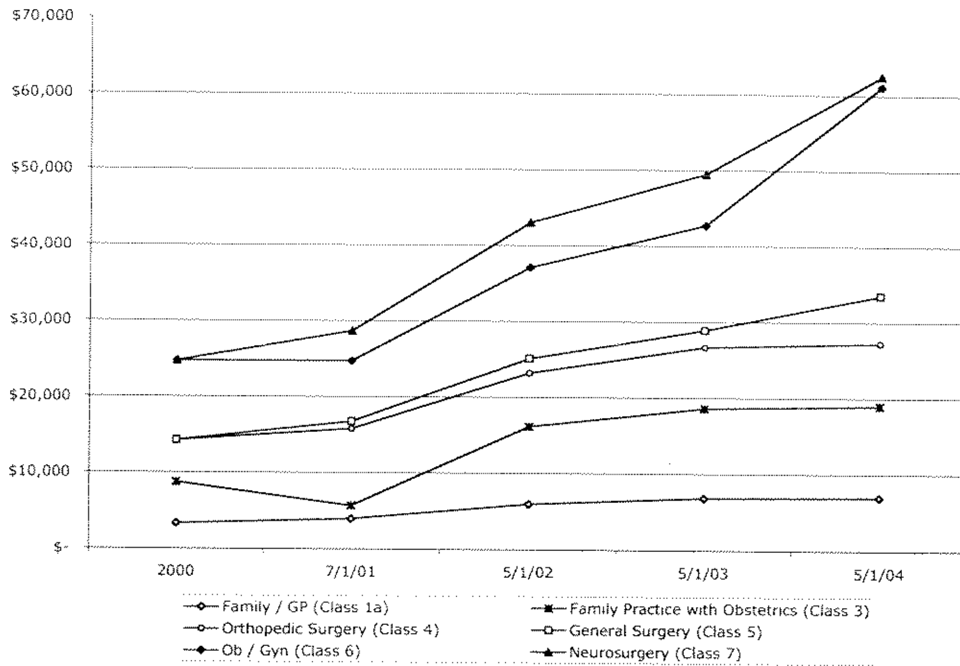


	Percentage Increase in Premiums Over Prior Years					Cumulative
Specialty	1999-2000	2000-2001	2001-2002	2002-2003	2003-2004	1999-2004
Family Practice	4%	30%	27%	38%	15%	172%
Family Practice with Obstetrics	4%	35%	59%	69%	15%	332%
Obstetrics	4%	20%	38%	63%	15%	221%
General Surgery	4%	30%	32%	44%	15%	196%
Neurosurgery	4%	35%	32%	43%	15%	206%
Orthopedic Surgery (No spine surgery)	4%	20%	27%	26%	15%	131%
Orthopedic Surgery (w/ spine surgery)	4%	20%	27%	81%	15%	231%

Source: Northwest Physicians Mutual

Figure 3 shows the same premium information from 2000 to 2004 for selected specialties for CNA insurance and demonstrate very similar trends. For general practitioners and family practitioners (Class 1a), rates have more than doubled with a 109 percent increase since 2000. As before, riskier practice areas have seen larger premium increases, with neurosurgery (Class 7) experiencing a 153 percent in crease in premiums and Ob/Gyn practices (Class 6) seeing a 147 percent increase in premiums from 2000 to 2004.

Figure 3: Malpractice Premium Levels and Increases for CNA (Selected Specialties)



	Percentage Increase in Premiums Over Prior Years				Cumulative
Specialty	2000-2001	2001-2002	2002-2003	2003-2004	2000-2004
Family / GP (Class 1a)	19%	50%	15%	2%	109%
Family Practice with Obstetrics (Class 3)	-35%	185%	15%	2%	117%
Orthopedic Surgery (Class 4)	11%	47%	15%	2%	91%
General Surgery (Class 5)	17%	50%	15%	16%	135%
Ob / Gyn (Class 6)	0%	50%	15%	43%	147%
Neurosurgery (Class 7)	16%	50%	15%	26%	153%

Source: CNA

Impacts of Increasing
Section II Medical Malpractice Insurance Rates

Increasing medical malpractice insurance rates have been associated with declining numbers of physicians and with increased diagnostic testing. Combined, these effects result in higher prices, longer waiting times, or longer travel times to receive physicians' services, and thereby reduce patient access to care.

Declining Numbers of Physicians

Increasing medical malpractice insurance rates have been associated with a declining number of physicians, especially in rural areas and in specialties experiencing the steepest premium increases. An OMA survey found that 12.0 percent of physicians in eastern Oregon reported that they already have or definitely will close or sell their practices.[12] While much of the extant literature focuses on anecdotal—rather than statistical—evidence,[13] one nationwide statistical study found that states with medical malpractice damage caps experienced a more rapid increase in their supply of physicians than states without such caps.[14]

A 2002 OHSU survey of obstetrical clinicians in Oregon showed that 34 percent of all those delivering babies have quit performing deliveries since 1999. Of these, 75 percent practice outside the Portland metropolitan area where more than one-half the State's women give birth. In addition, 31 percent of the then current obstetricians said they intended to quit deliveries within the next five years.[15]

An additional factor affecting physician supply in Oregon is the low rate of reimbursement, particularly for the care of Medicare and Medicaid patients. In a statement to Congress in May of 2004, the American Medical Association reported that from 1991 through 2005, medical practice costs will have increased by 41 percent; during the same time period, Medicare payments to physicians will only have increased by about 18 percent.

The medical liability environment may also have an impact on the number of new physicians practicing in Oregon, especially in those fields at a higher risk of medical malpractice liability. An AMA survey found that 96 percent of medical

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[12] Oregon Medical Association, Preliminary Report of the 2003 Physician Workforce Assessment, undated.

[13] See for example, U.S. Department of Health and Human Services, *Addressing the New Health Care Crisis: Reforming the Medical Litigation System to Improve the Quality of Health Care*, March 3, 2003 and *Confronting the New Health Care Crisis: Improving Health Care Quality and Lowering Costs By Fixing Our Medical Liability System*, July 24, 2002.

[14] Hellinger, Fred J. and William E. Encinosa, "The Impact of State Laws Limiting Malpractice Awards on the Geographic Distribution of Physicians," July 3, 2003.

[15] Smits, Ariel K., Elizabeth C. Clark, Mark Nichols, and John W. Saultz, "Factors Influencing Cessation of Pregnancy Care in Oregon," *Family Medicine*, Vol. 36, No. 7, pp. 490-5, July-August 2004.

school students believe the current medical liability environment to be a major problem or a crisis; 39 percent said that the medical liability environment affected their decision about the state in which they would complete their residency and 48 percent stated that liability affected their choice of specialty.[16] The impact of increasing premiums on these younger physicians contemplating the profession or entering practice in the state may be substantial. Unlike sales/closures of practices or retirements where announcements are made and the news gets out, the failure of new physicians to enter specialties within the state is difficult to monitor and evaluate. Ultimately this trend manifests itself in slow or negative growth in the physician population.

Reduced Access to Care

In general, a decline in the number of physicians offering services has resulted in reduced access to care. The OMA survey found that nearly one in eight physicians already has or definitely will close or sell his or her practice and 13.2 percent already have or definitely will stop providing direct patient care. Statewide, 26.1 percent of those in neurological surgery either have or will stop providing direct patient care.[17] Analysis by the OMA shows that in 2001, eastern Oregon had 56 head injuries but no neurosurgeons in the areas of the State where the injuries occurred. In contrast, central Oregon had 117 head injuries and 5 neurosurgeons.[18]

Other physicians are unable to get insurance because one of the two remaining insurers will not underwrite new policies for certain specialties. For example, the mayor of John Day, Oregon recently wrote a letter stating that the inability to get malpractice insurance—not a lack of physicians—would likely result in the loss of obstetrics services at the local hospital. If such services are lost, John Day patients would have to travel 75 miles to the nearest hospitals.[19]

Some physicians remaining in practice have stopped performing high-risk procedures in order to reduce their exposure to liability. The OMA's workforce assessment found that 21.2 percent of physicians in eastern Oregon intend to stop providing certain services. Statewide, 27.4 percent of those in obstetrics/gynecology and 23.1 percent in neurological surgery expect to stop providing certain services.[20]

The OMA survey found that the average surgeon rated the cost or availability of professional liability insurance as their most important factor regarding changes to their practices. Among eastern Oregon physicians, 29.2 percent already have or definitely will stop providing certain services because of changes to liability

[16] American Medical Association, *AMA Survey: Medical Students' Opinions of the Current Medical Liability Environment*, November 2003.

[17] Oregon Medical Association, Preliminary Report of the 2003 Physician Workforce Assessment, undated.

[18] Oregon Medical Association, *Oregon's Neurosurgeon Shortfall*, April 24, 2003.

[19] Letter from Roger Simonsen to Greg Walden, May 10, 2004.

[20] Oregon Medical Association, Preliminary Report of the 2003 Physician Workforce Assessment, undated.

insurance. Among all surgeons in the State, 23.5 percent already have or definitely will stop providing certain services because of changes to liability insurance.[21] This is consistent with a BlueCross Blue Shield survey: 56 percent of the plans surveyed in AMA-designated "crisis" states say physicians are refusing some high-risk procedures, versus 32 percent for non-crisis states.[22]

The GAO found instances of reduced access to hospital-based services affecting emergency surgery and newborn deliveries in scattered, often rural, areas where providers identified other long-standing factors that also affect the availability of services.[23] In addition to increasing medical malpractice premiums, Oregon's relatively low rate of Medicare reimbursement further reduces incentives for physicians to practice in Oregon, particularly in rural Oregon.[24]

Increased Health Care Costs

Increased medical malpractice insurance can lead to higher health care costs in three ways: pass-through of premium increases to patients and health insurers, reduced supply of health care services, and increased testing and procedures, i.e., *defensive medicine.*

Reduced supply of physicians and physician services

To the extent increased medical malpractice insurance premiums result in fewer doctors entering higher risk specialties, more early retirements, and fewer services offered, basic economics suggests that health care costs will increase. We are aware of no studies that empirically measure the impact of reduced supply on health care costs. Anecdotal evidence suggests that consumers bear higher costs through increased travel or waiting time to see a physician. For example, the GAO reported that pregnant women in a central Mississippi rural county that closed its obstetrics unit must travel about 65 miles to the nearest obstetrics ward to deliver.[25] The GAO made several attempts to verify longer wait times associated with reduced physician supply but found that the longer wait times cited by provider organizations were likely caused by factors other than malpractice pressures.[26]

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[21] Oregon Medical Association, Preliminary Report of the 2003 Physician Workforce Assessment, undated.

[22] BlueCross BlueShield Association, *The Malpractice Insurance Crisis: The Impact on Healthcare Cost and Access*, 2003. The American Medical Association has designated 12 states—including Oregon—in which rising medical malpractice insurance premiums have created a "crisis" situation.

[23] U.S. General Accounting Office, *Medical Malpractice: Implications of Rising Premiums on Access to Care*, GAO-03-836, August 2003.

[24] Office of Health Policy and Research, *Oregon's Health Care Trends*, Bruce Goldberg, January 21, 2004.

[25] U.S. General Accounting Office, *Medical Malpractice: Implications of Rising Premiums on Access to Care*, GAO-03-836, August 2003.

[26] U.S. General Accounting Office, *Medical Malpractice: Implications of Rising Premiums on Access to Care*, GAO-03-836, August 2003.

Increased practicing of defensive medicine

Defensive medicine is defined as medical care that is primarily or solely motivated by fear of malpractice claims and not by the patient's medical condition. The effect can manifest as the prescription of increased diagnosis and treatment procedures beyond what is needed form a purely clinical perspective, and the avoidance of procedures which might be appropriate from a clinical standpoint but whose risk level discourages their use.[27]

Proponents of limiting malpractice liability have argued that much greater savings in health care costs would be possible through reductions in the practice of defensive medicine.[28] In a study for the National Bureau of Economic Analysis, Stanford University researchers Daniel Kessler and Mark McClellan found that malpractice reforms that directly reduce clinician liability pressure lead to reductions of 5 to 9 percent in health care costs,[29] which translates to annual savings of about $60 billion. Within Oregon, an OMA survey reports that 25.2 percent in general surgery and 27.6 percent in orthopedic surgery have already increased the diagnostic procedures that they perform or plan on doing so. Over 20 percent of Oregon physicians surveyed have increased their referrals of complex cases or plan on doing so.[30]

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[27] *Liability for Medical Malpractice: Issues and Evidence*, Joint Economic Committee Study, May 2003 at 12.

[28] U.S. Congressional Budget Office, *Economic and Budget Issue Brief: Limiting Tort Liability for Medical Malpractice*, January 8, 2004.

[29] Kessler, Daniel and Mark McClellan, "Do Doctors Practice Defensive Medicine?" *Quarterly Journal of Economics*, May 1996. It is uncertain the extent to which these results can be generalized, see U.S. Congressional Budget Office, *Economic and Budget Issue Brief: Limiting Tort Liability for Medical Malpractice*, January 8, 2004. See also, Kessler, Daniel and Mark McClellan, "How Liability Law Affects Medical Productivity," *Journal of Health Economics*, 21 (2002) 931-955 at 935.

[30] Oregon Medical Association, Preliminary Report of the 2003 Physician Workforce Assessment, undated.

Section III

Causes of Increasing Medical Malpractice Insurance Rates

Increasing claims payments account for nearly all of the increase in medical malpractice premiums. Claims payments account for about two-thirds of insurers' total costs. Declining investment returns and reduced competition only account for a small portion of the increase in medical malpractice premiums and reinsurance costs are virtually irrelevant in Oregon.

Increased Claims Payments

Payments of claims are the most significant costs that malpractice insurers face, accounting for about two-thirds of their total costs.[31] Substantial increases in paid claims have a direct effect on the premiums paid by physicians. In Oregon, the average amount paid on claims has increased by 90 percent since damage caps were lifted in 1999 (Figure 4). The steepest increases have occurred in neurology/neurosurgery and obstetrics/gynecology. As shown in Figure 4, the average paid claims in Oregon surpassed the national average since 1999. During the time in which Oregon capped noneconomic damages, the average medical malpractice claim paid in Oregon was lower than the national average in all but three years.

The recent increase in the number of large payments accounts for the 90 percent growth in average claims payments in Oregon since 1999. Figure 5 shows claims payments of $1,000,000 or more, both as a share of the number of all paid claims and as the share of total dollars paid. As shown in this figure, 20 years ago payments of $1,000,000 or more constituted only 2 percent of paid claims and 23 percent of the total dollars paid. In first quarter of 2004 payments of $1,000,000 or more already constitute 46 percent of the paid claims and more than 85 percent of total dollars paid.

In addition to indemnity payments, costs of defending both Oregon paid claims and those claims closed without any payment have risen dramatically since 1982. Paid claim defense costs currently average $14,154 while closed without payment defense costs average $8,075. Since 1982, average defense costs for paid claims and claims closed without payment have risen 482 percent and 191 percent respectively.[32]

Oregon's experience is consistent with a national trend of increasing numbers of high-cost claims payments. Annual paid losses and incurred losses for the national medical malpractice insurance market began to rise more rapidly

[31] U.S. Congressional Budget Office, *Economic and Budget Issue Brief: Limiting Tort Liability for Medical Malpractice*, January 8, 2004.

[32] OMA Department of Medical-Legal Affairs

beginning in 1998.[33] The CBO noted that nationwide, the cost per successful claim has increased, but the rate of such claims has remained relatively constant.[34]

As noted above, Oregon has one of the shortest lags among the states between the time of incident and trial. This reduces the time during which premiums collected from physicians can earn a return in the insurance company's portfolio. In other words, Oregon faces a shorter lag between the collection of premiums and the payment of claims, which means that all other things equal, Oregon premiums are higher.

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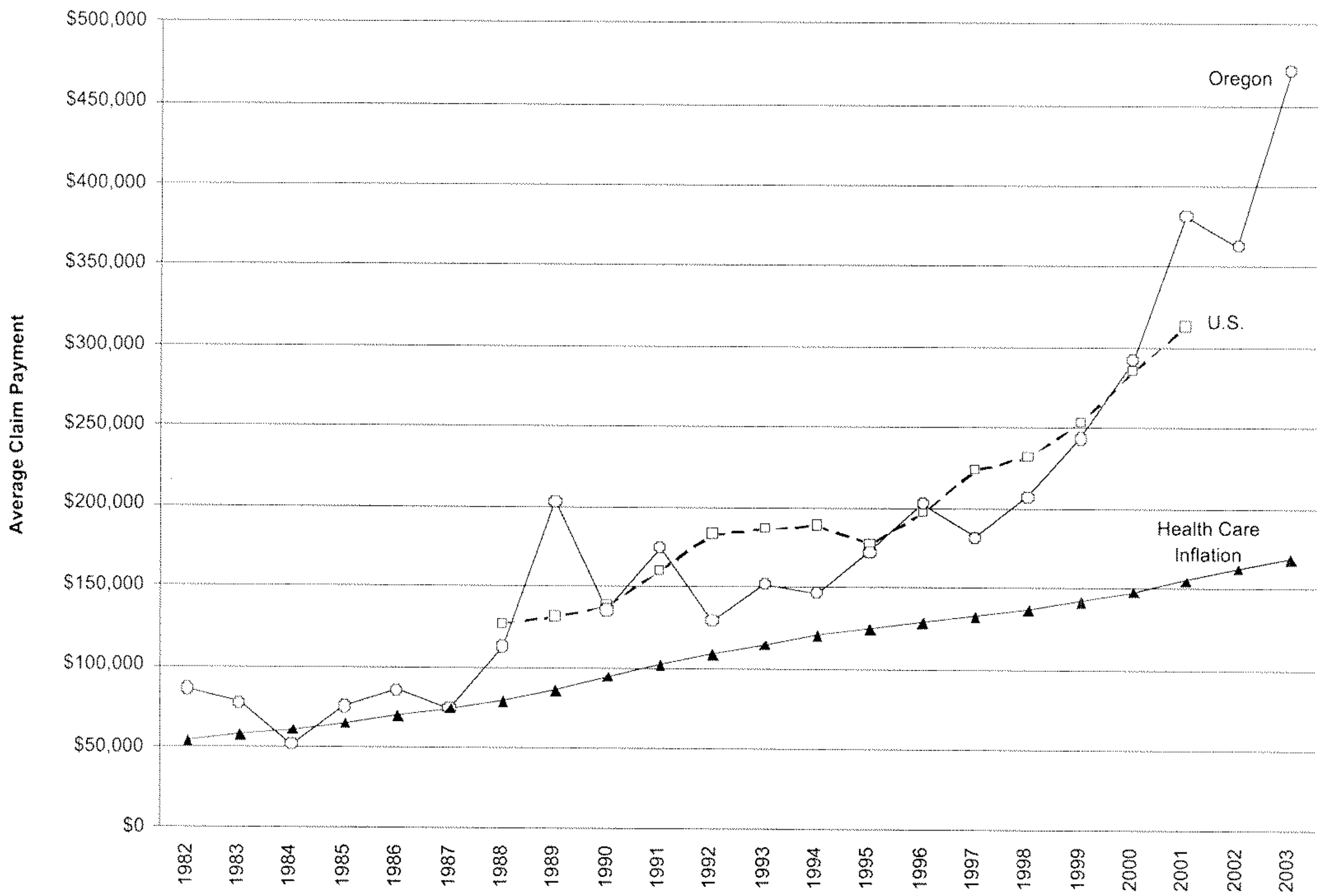
[33] U.S. General Accounting Office, *Medical Malpractice Insurance: Multiple Factors Have Contributed to Increased Premium Rates*, GAO-03-702, June 2003.

[34] U.S. Congressional Budget Office, *Economic and Budget Issue Brief: Limiting Tort Liability for Medical Malpractice*, January 8, 2004.

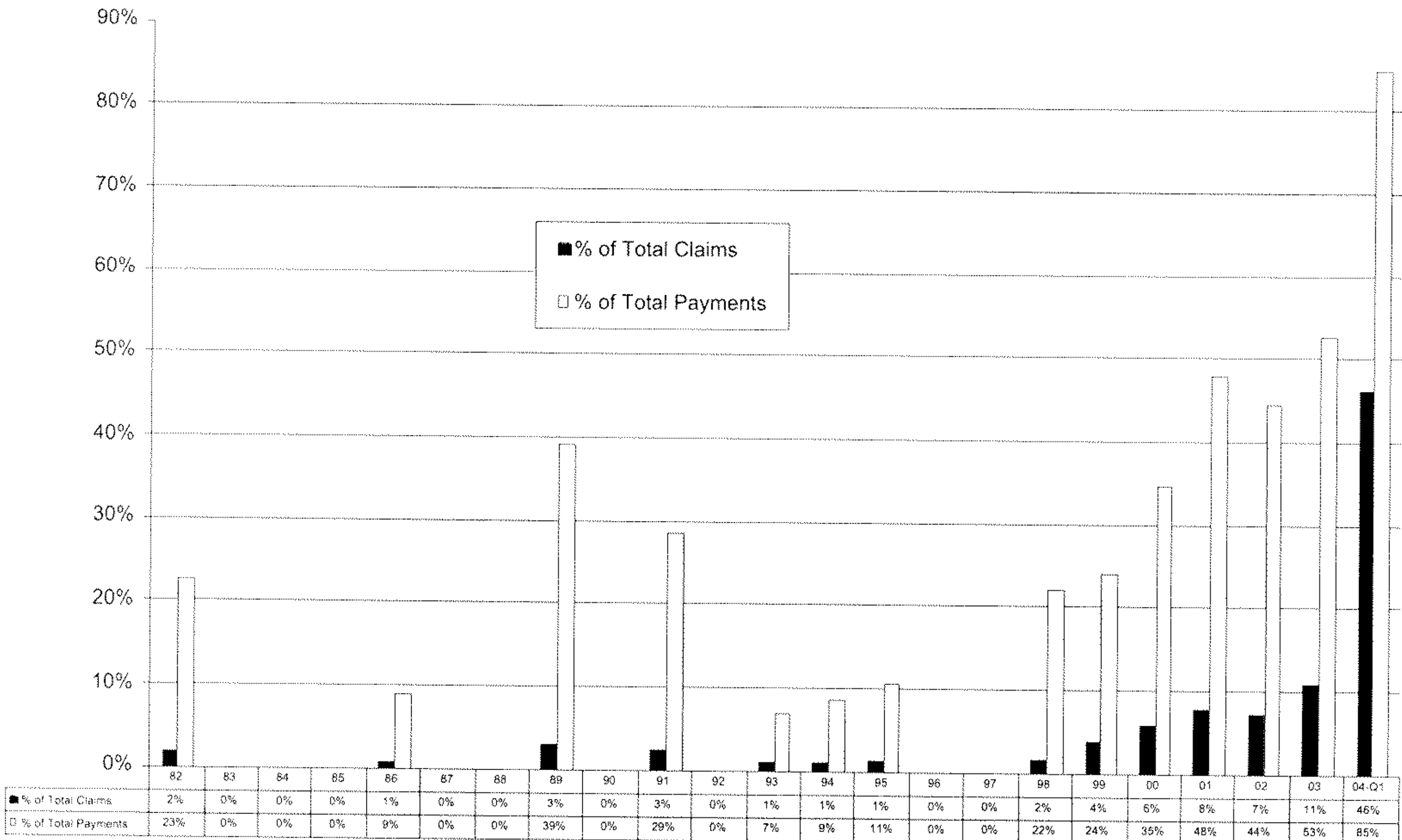
Figure 4: Average Payment on Medical Malpractice Claims, U.S. and Oregon, 1982-2003



Sources: PIAA; OMA

Figure 5: **Annual** Medical Malpractice Claims Paid in Oregon, 1982-2004

Total Oregon Million Dollar Paid Claims and Total Milion Dollar Payments as a Percentage of All Payments 1982-2004 (Q1)



	82	83	84	85	86	87	88	89	90	91	92	93	94	95	96	97	98	99	00	01	02	03	04-Q1
■ % of Total Claims	2%	0%	0%	0%	1%	0%	0%	3%	0%	3%	0%	1%	1%	1%	0%	0%	2%	4%	6%	8%	7%	11%	46%
□ % of Total Payments	23%	0%	0%	0%	9%	0%	0%	39%	0%	29%	0%	7%	9%	11%	0%	0%	22%	24%	35%	48%	44%	53%	85%

Sources: PIAA; OMA

Reinsurance

Some insurers purchase *reinsurance*, or excess loss coverage, to protect themselves against large unpredictable losses. Medical malpractice insurers, particularly smaller insurers, depend heavily on reinsurance because of the potentially high payouts on medical malpractice claims. Increases in medical malpractice premium rates have been attributed to the increased cost of reinsurance that, in turn, increases the total expenses that premiums and other income must cover.[35] The increased costs of reinsurance, in turn, have been attributed to the increased severity of claims payments.

In Oregon, the costs of reinsurance are not a component of premiums. Moreover, many insurers, including CNA, do not purchase reinsurance.

Reduced Investment Income

Medical malpractice insurers are required by state insurance regulations to reflect *expected* investment income in their premium rates. Opponents of tort reform have erroneously asserted that premium increases are driven by insurers' efforts to recoup stock market losses. These assertions are incorrect for the following reasons.

- Oregon insurance regulations prohibit calculation of insurance rates to recoup past losses or restore capital.[36]
- Most insurers' assets are in bonds. Medical malpractice insurers' portfolios, on average, held less than 10 percent in equities.[37]
- In the last 15 years, no Oregon insurance providers have experienced any losses in their portfolios.[38]

For these reasons, the impact of reduced investment income is indirect in that it adjusts providers' *expectations* of future investment income.

In Oregon, changes in investment returns likely provide little explanation for the increases in medical malpractice premiums. Empirically, a 1 percentage point decrease in investment income has been associated with a 2 to 4 percent increase in premiums.[39] The rate of return of one Oregon insurer peaked in 1997 at 6.51

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[35] U.S. General Accounting Office, *Medical Malpractice Insurance: Multiple Factors Have Contributed to Increased Premium Rates*, GAO-03-702, June 2003.

[36] Stegeman, Ronald and Sharon Robinson, *Medical Liability Insurance: Statement of CNA Insurance Companies*, Oregon House of Representatives Judiciary Committee, March 10, 2003.

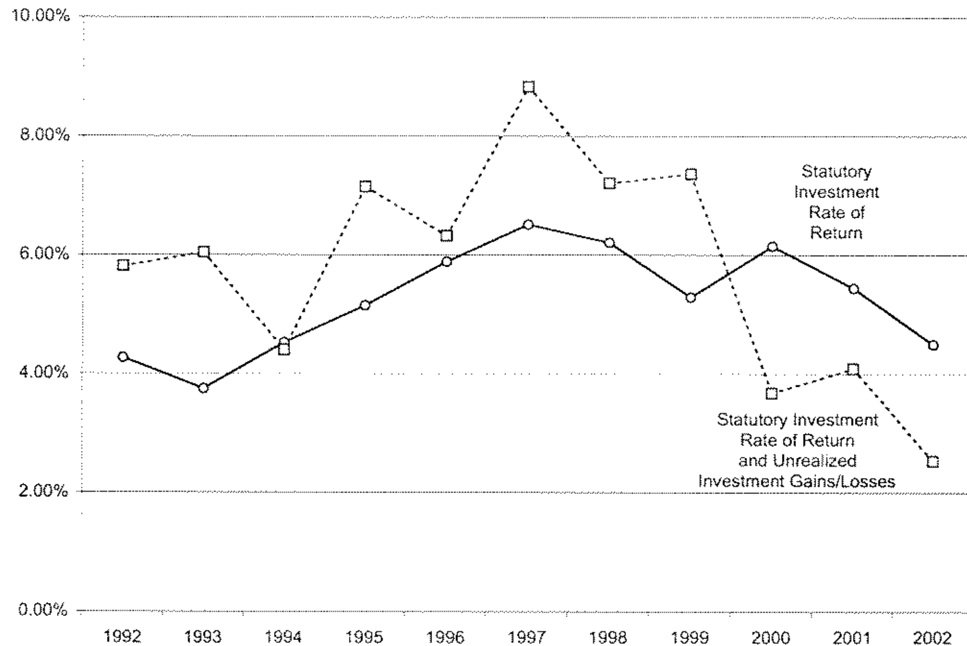
[37] Ramachandran, Raghu, *Did Investments Affect Medical Malpractice Premiums?*, January 21, 2003.

[38] Governor's Medical Professional Liability Task Force, 2002

[39] Hurley, James, Assessing the Need to Enact Medical Liability Reform, U.S. House of Representatives Subcommittee on Health, Committee on Energy and Commerce, February 27, 2003; Thorpe, Kenneth, "The Medical Malpractice 'Crisis': Recent Trends and the Impact of State Tort Reforms," *Health Tracking*, January 21, 2004.

percent, and declined by 1.07 percentage points to 5.44 percent in 2002 (Figure 6). Over that same period, premiums increased by 111 percent, or 25 to 50 times more than explained by changes in investment income.

Figure 6: Investment Returns of Northwest Physicians Mutual, 1992-2002



Source: Northwest Physicians Mutual

Reduced Competition

Declining profitability among insurers has caused some large insurers either to stop selling medical malpractice policies altogether or to reduce the number they sell. For example, the St. Paul Companies—previously the second-largest medical malpractice insurer in the United States—stopped writing all medical malpractice insurance beginning in 2002 because of declining profitability.[40] Oregon has seen ten insurers leave the State; one former insurer – Farmers Insurance – sold policies to hospitals under the Truck Insurance Exchange name. With the exit of Farmers in 2003, AIG is now the only insurance provider to Oregon hospitals. Other insurers have restricted the writing of new business. For example, Northwest Physicians Mutual has stopped writing most new obstetrician/gynecologist or family practice/obstetrician business.[41]

[40] U.S. General Accounting Office, *Medical Malpractice Insurance: Multiple Factors Have Contributed to Increased Premium Rates*, GAO-03-702, June 2003.

[41] Oregon Department of Consumer and Business Services, *Target Report of Financial Examination of Northwest Physicians Mutual Insurance Company*, June 30, 2002.

The reduced competition associated with firms exiting the business does not necessarily result in above-competitive pricing. In Oregon, CNA and Northwest Physicians Mutual together have comprised approximately 70 percent of the market since 1984.[42] Because they comprise such a large portion of the market, and have for some time, the exit of some of the smaller firms likely placed little upward pressure on pricing. Evidence suggests that medical malpractice premiums are not generating above-competitive profits for insurers for the following reasons.

- If the higher premium rates were above what was justified by insurers' expected losses, profitability would be increasing. But profits are not increasing, indicating that insurers are not charging and profiting from excessively high premium rates.[43] For example, Northwest Physicians Mutual has had four years of unprofitability since 1999.[44]

- Physician-owned insurers have little incentive to overcharge their policyholders because those insurers generally return excess earnings to their policyholders in the form of dividends.[45]

- Insurance regulators in most states—including Oregon—have the authority to deny premium rate increases they deem excessive. The Oregon Department of Consumer and Business Services allows for a public hearing for any rate increase or decrease of 15 percent or more.[46]

[42] The Business Journal of Portland, "Insurers' pain symptom of state wide problem", June 14, 2004.

[43] U.S. General Accounting Office, *Medical Malpractice Insurance: Multiple Factors Have Contributed to Increased Premium Rates*, GAO-03-702, June 2003.

[44] Northwest Physicians Mutual, "Did Mismanagement Cause This Crisis?" undated.

[45] U.S. General Accounting Office, *Medical Malpractice Insurance: Multiple Factors Have Contributed to Increased Premium Rates*, GAO-03-702, June 2003.

[46] Oregon Revised Statute §737.207.

Section IV

The Effects of Capping Noneconomic Damages

As of 2002, more than 40 states had at least one restriction on medical malpractice liability in effect.[47] Available evidence indicates that such limits reduce malpractice payments and, in turn, malpractice insurance premiums. Available evidence also indicates that such limits likely have no impact on the incidence of malpractice.

Reduced Medical Malpractice Insurance Premiums

Figure 5 shows the number of million dollar claims in Oregon since 1982, and the share these claims comprise of the total number of claims and total claim payments. With the lifting of caps in 1999, both the number and amount of million dollar claims as a share of the total has increased dramatically. As shown in Figure 4, the average amount of paid claims also increased substantially during this period, with Oregon rising well above the national average. Premiums in Oregon reflect this trend; premiums decreased substantially after 1987, remained stable throughout the 1990s, and increased substantially after 1999 (see Figure 1, Figure 2 and Figure 3).

In addition to the reduced exposure to payments, caps provide insurers greater predictability in what they will have to pay out in noneconomic damages because they can more easily estimate potential losses. Therefore caps reduce the uncertainty that can give rise to premium rate increases. The GAO reported that, according to insurers, economic damages are more predictable than noneconomic damages because damages for things such as pain and suffering are very difficult to quantify.[48]

From 1987 to 1999, Alabama established three sets of caps on noneconomic damages against health care providers in all other civil litigation matters. Through a series of court decisions, each of the caps was removed. During the period in which all three caps were in place, the average medical malpractice payout was $23,300 lower than the period before the caps were in place. During the period in which all the caps were removed, the average medical malpractice payout was approximately $49,400 higher than the period in which all three caps were in place.[49]

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[47] U.S. Congressional Budget Office, *Economic and Budget Issue Brief: Limiting Tort Liability for Medical Malpractice*, January 8, 2004.

[48] U.S. General Accounting Office, *Medical Malpractice Insurance: Multiple Factors Have Contributed to Increased Premium Rates*, GAO-03-702, June 2003.

[49] Yoon, Albert, "Damage Caps and Civil Litigation: An Empirical Study of Medical Malpractice Litigation in the South," *American Law and Economics Review*, 2001, pp. 199-227.

In 1993, the Office of Technology Assessment concluded that caps on damage awards consistently reduced the size of claims and consequently premium rates for malpractice insurance. Its conclusions were based upon a summary of studies on the experience of states that set limits on malpractice liability in the 1970s and 1980s.[50]

A 2003 study examining state data from 1993 to 2002 found that two restrictions—a cap on noneconomic damages and a ban on punitive damages—would together reduce premiums by more than one-third (all other things being equal). The Congressional Budget Office (CBO) estimated that the provisions of the Help Efficient, Accessible, Low-cost, Timely Healthcare (HEALTH) Act of 2003 would lower premiums nationwide by an average of 25 percent to 30 percent.[51]

A Caltech dissertation completed in 2003 concluded that damage caps reduce medical malpractice insurance premiums. The results were derived from data on medical malpractice insurance premiums per physician in the 50 states for the period 1991-2001.[52]

A 2004 study concludes that states that enacted caps on noneconomic damages at or below $500,000 and set limits on joint and several liability have had significantly lower premium increases than states without such caps.[53]

During the period in which Oregon capped noneconomic damages, the State's medical malpractice premiums declined by more than 50 percent (Figure 1). Since the caps have been lifted, premiums have more than doubled for most specialties.

Reduced Health Care Costs

A 2002 study found that physicians from states adopting malpractice liability reforms that directly limit awards—such as caps on noneconomic damages—saw a 1.4 percent point reduction in claims rates. Such a decrease was associated with a 3.9 to 4.2 percent reduction in hospital expenditures.[54] This study supported an early study by the authors that found that direct limits led to statistically

[50] U.S. Office of Technology Assessment, *Impact of Legal Reforms on Medical Malpractice Costs*, OTA-BP-H-119, September 1993.

[51] U.S. Congressional Budget Office, *Economic and Budget Issue Brief: Limiting Tort Liability for Medical Malpractice*, January 8, 2004.

[52] Zeiler, Kathryn, *Medical Malpractice and Contract Disclosure: A Study of the Effects of Legal Rules on Behavior in Health Care Markets*, dissertation, May 20, 2003.

[53] Danzon, Patricia M., Andrew J. Epstein, and Scott Johnson, "The 'Crisis' in Medical Malpractice Insurance," Presented at the Brookings-Wharton Conference on Public Policy Issues Confronting the Insurance Industry, December 2004.

[54] Kessler, Daniel and Mark McClellan, "How Liability Affects Medical Productivity" *Journal of Health Economics*, November 2002. It is uncertain the extent to which these results can be generalized, see U.S. Congressional Budget Office, *Economic and Budget Issue Brief: Limiting Tort Liability for Medical Malpractice*, January 8, 2004.

significant reductions in medical expenditure growth.[55] A 1999 study examining the effect of tort limits on the proportion of births by cesarean section found cost savings of 0.27 percent.[56]

According to the CBO, malpractice costs nationally amounted to an estimated $24 billion in 2002, or less than 2 percent of overall health care spending. It concluded that, all other things held constant, a reduction of 25 percent to 30 percent in malpractice costs would lower health care costs about 0.4 percent to 0.5 percent, with comparable effects on health insurance premiums.[57]

For Oregon, higher medical malpractice rates are impacting the cost of care both directly and indirectly through higher taxes needed to provide services through the Oregon Health Plan. In 2002, the Oregon Department of Human Services (DHS) estimated that the average cost of baby deliveries covered by the OHP would increase by $300 (31 percent) due in part to the increases in medical malpractice insurance premiums.[58] In response, the 2002 DHS budget request proposed increases for both fee-for service rates and capitation payments to increase reimbursements to obstetricians and family practitioners that provide prenatal care and deliver babies. The requested increase totaled $1.9 million in General Funds ($4.7 million total when funds from other sources were included.) The increase in medical malpractice insurance premiums was cited as the primary reason for requesting the additional funds.[59]

No Change in the Incidence of Malpractice

Opponents of caps argue that restrictions on malpractice liability could undermine the deterrent effect of such liability and thus lead to higher rates of medical injuries. The CBO did not agree with this argument and concluded that "it is not obvious" that the current tort system provides effective incentives to deter medical injuries for the following reasons.[60]

- Malpractice insurance itself dampens health care providers' exposure to the financial cost of their own malpractice risk. The premiums for such insurance tend not to reflect the records or practice styles of individual providers but reflect more general factors such as location and medical specialty.

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[55] Kessler, Daniel and Mark McClellan, "Do Doctors Practice Defensive Medicine?" *Quarterly Journal of Economics*, May 1996.

[56] Dubay, Lisa, Robert Kaestner, and Timothy Waidmann, "The Impact of Malpractice Fears on Cesarean Section Rates," *Journal of Health Economics*, August 1999.

[57] U.S. Congressional Budget Office, *Economic and Budget Issue Brief: Limiting Tort Liability for Medical Malpractice*, January 8, 2004.

[58] Crawford, Herschel, email to Scott Gallant OMA, August 19, 2002.

[59] Oregon Department of Human Services, Request to Oregon Legislature to Approve DHS 2001-03 Rebalance Plan, November 7, 2002.

[60] U.S. Congressional Budget Office, *Economic and Budget Issue Brief: Limiting Tort Liability for Medical Malpractice*, January 8, 2004.

- Very few medical injuries ever become the subject of a claim. A 1984 New York study cited by CBO estimates that 1.5 percent of cases of medical negligence that occurred in hospitals throughout the state that year led to claims.[61]

The scant evidence available so far does not indicate that restricting malpractice liability would have a significant effect, either positive or negative, on the incidence of malpractice.[62]

As stated in a 2002 study by Kessler and McClellan, only one in fifteen patients who suffer an injury due to medical negligence receives compensation, and five sixths (83 percent) of the cases that receive compensation have no evidence of negligence. Rather, the primary determinant of whether an injury will receive compensation is the extent of the injury, not the extent of fault.[63]

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[61] U.S. Congressional Budget Office, *Economic and Budget Issue Brief: Limiting Tort Liability for Medical Malpractice*, January 8, 2004.

[62] U.S. Congressional Budget Office, *Economic and Budget Issue Brief: Limiting Tort Liability for Medical Malpractice*, January 8, 2004.

[63] Journal of Health Economics 21(2002) 931-955 "How Liability Law Affects Medical Productivity," Daniel B. Kessler, Mark B McClellan.

Section V

Conclusions

Medical malpractice insurance premiums for Oregon physicians have seen enormous increases in recent years, and rates for doctors performing inherently high risk procedures have increased the most. Although there are several factors that have contributed to the sharp increase in medical malpractice insurance premiums, claims payments are the largest component of insurer costs and increases in malpractice damage awards will increase premiums accordingly.

As our analysis of claims data shows, the number of claims has decreased by more than 54 percent since Oregon imposed a damage cap in 1987 and remained at or below this figure even after the damage cap was removed; the average payment (claim severity) has increased by 449 percent during the same period. Twenty years ago, payments of $1,000,000 or more constituted only 2 percent of paid claims, and 23 percent of the total dollars paid, in first quarter of 2004, payments of $1,000,000 or more constituted 46 percent of the paid claims and more than 85 percent of total dollars paid. Since caps on non-economic damages were lifted following the Oregon Supreme Court's 1999 *Lakin v. Senco* decision, the average medical liability payment has grown by 90 percent from $247,000 to $470,000.

Based on our research of healthcare trends within Oregon, experience in other states with limits on malpractice damage awards, and studies conducted nationally and in other regions, it appears that capping non-economic damages in medical malpractice cases will reduce medical malpractice insurance premiums. Reduced premiums should reduce the cost of health care and increase the supply of health care services offered in Oregon over time.

From our research, we draw the following conclusions:

- **Increasing medical malpractice premiums will ultimately reduce the number of physicians providing procedures that carry the higher premiums**. Increasing medical malpractice insurance rates have been associated with a declining number of physicians in Oregon, especially in rural areas and those specialties experiencing the steepest premium increases. A survey of doctors within Oregon indicates that many are planning to stop performing inherently high risk procedures and are considering retiring. Unless the situation changes, the current medical liability environment will discourage efforts to attract new physicians to the State.

- **Increasing claims payments account for nearly all of the increase in medical malpractice premiums**. Claims payments account for about two-thirds of insurers' total costs, and increases in claims will increase overall insurance costs and ultimately increase premiums. Declining investment returns and reduced competition only account for a small portion of the increase in medical malpractice premiums.

- **Capping noneconomic damages would likely reduce medical malpractice premiums**. Evidence from Oregon's earlier experience and that of other states indicate that such limits reduce malpractice payments and, in turn, malpractice insurance premiums. Evidence in the literature also indicates that such limits can reduce health care costs.

STATE OF WISCONSIN
COURT OF APPEALS
DISTRICT III

DAVID ZAK and KIM ZAK,

Plaintiffs-Respondents-Cross-Appellants,

v. **Case No. 04AP2698**

JOCKO ZIFFERBLATT, D.O., INFINITY HEALTHCARE PHYSICIANS, S.C., and PHYSICIANS INSURANCE COMPANY OF WISCONSIN, INC.,

Defendants-Appellants-Cross-Respondents,

SCOTT PERKL, P.A., MICHAEL J. CUTOGNO, M.D., ST. VINCENT HOSPITAL OF THE HOSPITAL SISTERS OF THE THIRD ORDER OF ST. FRANCIS, and WISCONSIN PHYSICIANS SERVICE INSURANCE COMPANY,

Defendants,

WISCONSIN PATIENTS COMPENSATION FUND,

Defendant-Cross-Respondent,

SENTRY SELECT INSURANCE COMPANY,

Nominal-Defendant.

COMBINED BRIEF OF APPELLANTS-CROSS RESPONDENTS

JOCKO ZIFFERBLATT, D.O., INFINITY HEALTHCARE PHYSICIANS, S.C., and PHYSICIANS INSURANCE COMPANY OF WISCONSIN, INC.

Appeal from the Circuit Court for Marinette County:
The Honorable David G. Miron, Presiding

By: FOLEY & LARDNER LLP

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