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**STATEMENT OF JOANNE DOROSHOW**
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**BEFORE THE GOVERNOR'S SELECT TASK FORCE ON HEALTHCARE PROFESSIONAL LIABILITY INSURANCE**

**Orlando, Florida**
**October 21, 2002**

Mr. Chairman, and members of the Task Force, I am Joanne Doroshow, President and Executive Director of the Center for Justice & Democracy, a national public interest organization that is dedicated to educating the public about the importance of the civil justice system. I am also a founder of Americans for Insurance Reform (AIR), a coalition of nearly 100 organizations representing over 50 million people that advocates insurance reforms as the only way to solve the current insurance "crisis" and prevent future ones. AIR's members include the Florida Consumer Action Network and the Florida Public Interest Research Group. I appreciate the opportunity to address the issue of medical malpractice insurance today.

Following the conclusion of this written testimony, you will find a list of major tort restrictions in medical malpractice cases that state lawmakers have enacted through 1999. These laws were passed after medical and insurance lobbyists told lawmakers that legislation was needed to reduce medical malpractice insurance rates, just as they are telling you today. It should be noted that this extensive list does not include every state restriction on patients' right to sue, such as laws found in many states requiring patients to present affidavits or "certificates of merit" before cases can even be brought. As a result of these laws, doctors and hospitals already have more legal protections from lawsuits than any other profession or business in the nation.

Today, I would like to discuss why these laws have had terrible consequences for patients while doing nothing to improve the affordability or availability of insurance.

For the last 17 years, doctors and hospitals nationwide have experienced a relatively stable medical malpractice insurance market. Insurance was available and affordable. Rate increases were modest. In fact, over the last 10 years, average premiums increased by only 1.9 percent nationwide, far below medical inflation. Meanwhile, profits for medical malpractice insurers soared, generated by high investment income.

Medical malpractice insurance companies are now experiencing a downturn and they are raising premiums and canceling coverage for doctors, or at least threatening to do so, in virtually every

state in the country. One insurance insider, Richard G.M. Marko, senior Vice President of National Markets at Liberty Mutual Insurance Co. in Boston, recently told an insurance audience that from 1994 to 1999, insurance rates decreased by about 50 percent and that now, after two straight years of increasing rates, only about half of that decrease has been made up.

This is not a state-specific phenomenon. This is not even a country-specific phenomenon. Over the past year, industry publications like *Best Wire* and *Best's Insurance News* have reported repeatedly on a similar insurance crisis that exists in Australia, and on price hikes that Canadian policyholders are starting to experience. Provinces in these countries do not even have civil jury trials.

Moreover, this so-called insurance "crisis" is an exact repeat of the last insurance "crisis" that hit Florida, California (which had passed its cap on damages 10 years earlier) and indeed the entire United States in the mid-1980s, as well as an earlier "crisis" in the mid-1970s. As its predecessors, today's insurance "crisis" has absolutely nothing to do with Florida's legal system, tort laws, lawyers or juries in medical malpractice cases. It is driven by the insurance underwriting cycle and remedies that do not specifically address this phenomenon will fail to stop these wild price gyrations in the future.

One solution that insurance and medical lobbies have proposed, capping damages awards, would be as egregious for patients and the quality of health care in Florida, as it would be ineffective in bringing insurance rates under control. It is based entirely upon a false predicate – that Florida's civil justice system is to blame for insurance price-gouging.

To summarize:

- **Volcanic eruptions in insurance premiums for doctors have occurred three times in the last 30 years.** The cause is always the same: a drop in investment income for insurers compounded by severe underpricing in prior years. This has been documented over and over again by insurance analysts. Each time, insurers have tried to cover up their mismanaged underwriting by blaming jury awards. Under this theory, one would have to believe that juries engineered high awards to precisely coincide with the insurance industry's economic cycle. In other words, one would have to accept the notion that juries engineered high awards in the mid 1970s, then stopped for a decade, then engineered high awards in the mid-1980s, stopped for 17 years and are now engineering high awards again. This is ludicrous.

- **Medical insurance premiums that insurance companies have charged doctors over the last 30 years have risen and fallen in concert with the state of the economy and have not corresponded to increases or decreases in payouts, which, in constant dollars, have been steady for 30 years.** In other words, insurance premiums (in constant dollars) increase or decrease in direct relationship to the strength or weakness of the economy, reflecting the gains or losses experienced by the insurance industry's market investments and their perception of how much they can earn on the investment "float" (which occurs during the time between when premiums are paid into the insurer and losses paid out by the insurer) that doctors' premiums provide them. On the other

hand, the amount that medical malpractice insurers have paid out, including all jury awards and settlements, directly tracks the rates of medical inflation. Not only has there been no "explosion" in medical malpractice payouts at any time during the last 30 years, but payments (in constant dollars) have been extremely stable and virtually flat since the mid-1980s.

- **In the midst of the last insurance "crisis" in the mid-1980s, Florida lawmakers enacted severe tort restrictions on patients' rights to reduce insurance rates. These laws had absolutely no impact on insurance rates.** In fact, immediately after enactment of Florida's laws in 1986, Aetna and St. Paul said they would not reduce rates. Moreover, filings by 104 insurers in Florida in 1986 showed that out of 277 filings, 175, or 63 percent, showed no savings from "tort reform" while none showed savings of more than 10 percent. [1] On the other hand, some states that resisted enacting any "tort reform" in the mid-1980s experienced low increases in insurance rates or loss costs relative to the national trends, and some states that enacted major "tort reform" packages saw very high rate or loss cost increases relative to the national trends. In other words, there is no correlation between "tort reform" and insurance rates.[2] Indeed, a few years after the mid-1980s insurance "crisis," the insurance cycle flattened out, rates stabilized and availability improved everywhere – until now, over a decade later. The flattening of rates had nothing to do with tort law restrictions enacted in particular states, but rather to modulations in the insurance cycle everywhere. In 1991, Washington's insurance commissioner Dick Marquardt concluded in a report that it was "impossible to attribute stable insurance rates to tort-law changes or the damages cap," since rates also improved in states that did not pass "tort reform." The American Insurance Association (AIA) and the American Tort Reform Association (ATRA) have admitted in published statements that lawmakers who enact "tort reforms" should not expect insurance rates to drop, most recently with the AIA saying in a March 13, 2002 statement, "[T]he insurance industry never promised that tort reform would achieve specific premium savings."

- **This year, in states that have taken the misguided approach of trying to solve their insurance problem by enacting "tort reform," insurance companies are refusing to reduce rates.** In Nevada, lawmakers were subjected to a nasty campaign by insurers and organized medicine during the summer of 2002, including the deliberate closing of trauma centers, in order to strong-arm the legislature into enacting severe caps on medical malpractice compensation. Insurance groups fought any attempt to add a provision to guarantee lower rates should the legislation pass. Within weeks of the law's enactment, two major insurance companies proclaimed that they would not reduce insurance rates. Similarly, in Mississippi, where a contentious medical malpractice "tort reform" battle was also waged during a special session this summer, Medical Assurance Co. of Mississippi notified doctors that it will raise its rates by 45 percent in 2003 "regardless of the special session outcome" since "tort reform" does "not provide a magical 'silver-bullet' that will immediately affect medical malpractice insurance rates."

- **A $250,000 cap on non-economic damages would have terrible consequences for many innocent patients.** Non-economic damages compensate injured consumers for the human suffering accompanying injuries caused by wrongful conduct. These are

intangible but real injuries, like infertility, permanent disability, disfigurement, pain and suffering, loss of a limb or other physical impairment. Caps on non-economic damages hurt those who suffer most – men, women and children who suffer brain injury, amputation, paralysis, quadriplegia and other devastating injuries. And they have a disproportionate effect on plaintiffs who do not have high wages, like children and seniors, who are more likely to receive a greater percentage of their compensation in the form of non-economic damages if they are injured.

History is clear on this matter: legislative attempts to reduce insurance rates by taking away the rights of the most seriously injured in our society has been and continues to be a failed public policy.

**California Is A Failed Model For Proposed National Restrictions On Patients' Rights**

In the mid-1970s, California enacted severe tort restrictions for patients who have been injured by malpractice (MICRA). Among other things, this law allows patients to recover no more than $250,000 in non-economic compensation no matter how egregious the malpractice or serious the injury; prohibits patients from receiving damages in a lump sum; repeals the collateral source rule; and imposes restrictions on the attorneys' fees of patients. The medical establishment is campaigning to spread this law, one of the most draconian in the nation, to other states, arguing falsely that this cap has kept premiums down dramatically.

Data that show California's MICRA law has failed to slow premium increases for doctors and hospitals. In fact, over the last decade, the average malpractice premium in California has grown *more quickly* than it has in the nation overall.

This actuarial analysis was done by nationally recognized actuary J. Robert Hunter, former Texas Insurance Commissioner and Federal Insurance Administrator under Presidents Ford and Carter, who compared national malpractice premium trends to those in California. Hunter found that from 1991 to 2000, malpractice premiums in California stayed close to national premium trends. The 2000 average premium per doctor in California was only 8.2 percent below that of the nation ($7,200.61 vs. $7,843.75) while the average malpractice premium in California between 1991 and 2000 actually grew more quickly (3.5 percent) than it did in the nation overall (1.9 percent.) According to Hunter, "There is not much difference in the rates or the rate of change between California and the nation based on the latest decade of experience."

This analysis exposes as an insidious public relations scam the notion that California's cruel law has controlled the growth of malpractice insurance premiums. This law has had terrible consequences for many innocent people, while doing nothing to improve the affordability of liability insurance for doctors. Jamie Court, Executive Director of the Foundation for Taxpayer and Consumer Rights, says, "California is a failed model for the national restrictions being proposed on patients. California patients have been denied adequate compensation and representation for their injuries, and California doctors have seen almost no premium savings. Only the insurers have gotten rich in the good times." These data are found in the following table:

| YEAR | CALIFORNIA NUMBER OF DOCTORS IN STATE | U.S.A. NUMBER OF DOCTORS | CALIFORNIA MEDICAL MALPRACTICE PREM EARNED (in thousands) | U.S.A. MEDICAL MALPRACTICE PREM EARNED (in thousands) | AVERAGE MED MAL PREMIUM PER DOCTOR CALIFORNIA | AVERAGE MED MAL PREMIUM PER DOCTOR U.S.A. |
|---|---|---|---|---|---|---|
| 1991 | 76043 | 631400 | 529056 | 4862170 | 6957.33 | 7700.62 |
| 1992 | 76367 | 652100 | 526496 | 5138395 | 6894.29 | 7879.77 |
| 1993 | 76411 | 670300 | 563004 | 5174055 | 7368.10 | 7719.01 |
| 1994 | 77311 | 684400 | 576771 | 5931898 | 7460.40 | 8667.30 |
| 1995 | 78169 | 720300 | 597660 | 6080639 | 7645.74 | 8441.81 |
| 1996 | 79048 | 737800 | 610003 | 5992394 | 7716.87 | 8121.98 |
| 1997 | 80341 | 756700 | 628858 | 5917038 | 7827.36 | 7819.53 |
| 1998 | 81762 | 777900 | 652601 | 6195047 | 7981.72 | 7963.81 |
| 1999 | 82872 | 797600 | 611785 | 6155241 | 7382.29 | 7717.20 |
| 2000 | 84675 | 812800 | 609712 | 6375401 | 7200.61 | 7843.75 |
| | | | 1991 to 2000 percent change | | 3.5 | 1.9 |
| | | | 1991 to 2000 % change (annualized) | | 0.4 | 0.2 |

**Sources:** Doctors USA: Statistical Abstract of the U.S.
Doctors CA: California Department of Consumer Affairs;
Earned Premiums: NAIC Report On Profit By Line By State

The consequences for patients of California's MICRA law have been, quite simply, unfathomable. In his upcoming book *Corporateering: How the Invisible Hand Steals the Individual's Freedom,* Jamie Court of California's Foundation for Taxpayer and Consumer Rights, writes:

> Twelve year old Steven Olsen is blind and brain damaged because, as a jury ruled, he was a victim of medical negligence when he was two years old. He fell on a stick in the woods while hiking. Under the family's HMO plan, the hospital pumped Steven up with steroids and sent him away with a brain tumor, although his parents had asked for a CAT scan because they knew Steven was not well. Steven Olsen came back to the hospital comatose. At trial, medical experts testified that had he received the $800 CAT scan, which would have detected a growing brain mass, he would have his sight and be healthy today.
>
> The jury awarded $7.1 million in non-economic damages for Steven's avoidable life of darkness and suffering. However, the jury was not told of a two-decade-old restriction on non-economic damages in the state. The judge was forced to reduce the amount to $250,000. The jurors only found out that their verdict had been reduced by reading about it in the newspaper. Jury foreman Thomas Kearns expressed his dismay in a letter published in the *San Diego Union Tribune:*

> "We viewed video of Steven, age 2, shortly before the accident. This beautiful child talked and shrieked with laughter as any other child at play. Later, Steven was brought to the court and we watched as he groped, stumbled and felt his way along the front of the jury box. There was no chatter or happy laughter. Steven is doomed to a life of darkness, loneliness and pain. He is blind, brain damaged and physically retarded. He will never play sports, work, or enjoy normal relationships with his peers. His will be a lifetime of treatment, therapy, prosthesis fitting and supervision around the clock."

Our medical-care system has failed Steven Olsen, through inattention or pressure to avoid costly but necessary tests. Our legislative system has failed Steven, bowing to lobbyists of the powerful American Medical Association (AMA) and the insurance industry, by the Legislature enacting an ill-conceived and wrongful law. Our judicial system has failed Steven, by acceding to this tilting of the scales of justice by the Legislature for the benefit of two special-interest groups. I think the people of California place a higher value on life than this.

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

**Has the Cap on Damages Kept Doctors in California? No.** While California is touted by "tort reform" groups as a highly attractive state for doctors to practice because of the state's $250,000 cap, the U.S. Census Bureau reports that California is falling in the number of doctors, per capita, compared to the population. The California Medical Association blames the physician exodus on low Medicare/Medicaid reimbursements, a problem that has had far greater impact on a doctor's willingness to practice in a state than tort restrictions.

## A New Insurance "Crisis" Takes Hold

In the mid-1980s, lawmakers in many states, including Florida, passed tort restrictions in medical malpractice cases after being told by insurance companies and others that this was the only way to reduce skyrocketing insurance rates for doctors. Lawmakers were responding to news reports like these, virtually identical to the reports of today:

- "An American Medical Association official says escalating costs of medical malpractice insurance are increasing health-care costs for the public and forcing doctors to curtail some services." *Baton Rouge Morning Advocate,* **May 31, 1986.**

- "Doctors are threatening to quit practicing some specialties or move out of the state while South Florida hospitals and trauma centers have threatened to shut down or have curtailed services." *St. Petersburg Times,* **May 7, 1987.**

- "Busloads of physicians from around [New York] state will travel to Albany on Wednesday, May 21, to rally for legislative reform of the state's medical liability system." *PR Newswire,* **May 19, 1986.**

- "Doctors and hospitals in [West Virginia] have been saying for weeks that they would have to close their doors at the end of this month when three major insurance companies planned to cancel malpractice insurance coverage for most of the state's medical providers." *Washington Post,* **May 24, 1986.**

- "Hundreds of doctors, especially those in high-risk specialties like obstetrics and orthopedics, refused to accept new patients last February when a state Insurance Division decision opened them up to massive retroactive premium increases." *The Record (New Jersey),* **July 24, 1986.**

Three times in the last 30 years, the insurance industry has created liability insurance "crises," making insurance unaffordable or, in some cases, unavailable at any price for many doctors, businesses and other professions. A first crisis happened in the mid-1970s, precipitating the first wave of "tort reform" in medical malpractice insurance and product liability insurance, particularly.

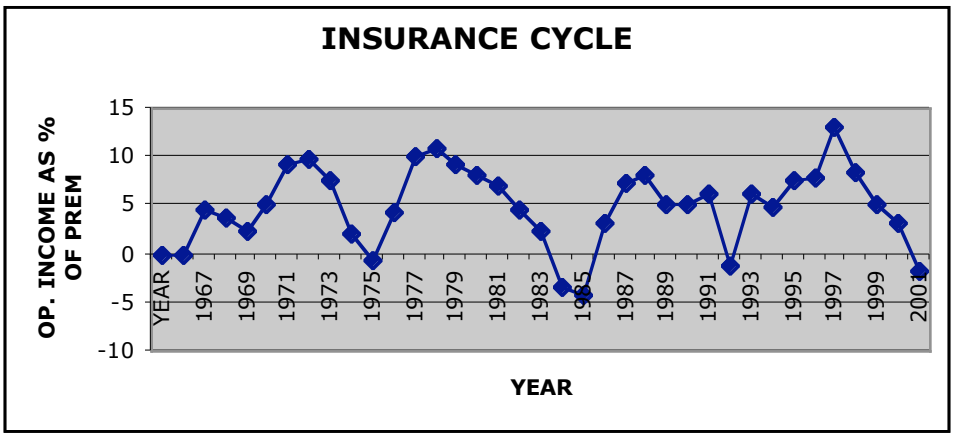
A more severe crisis took place in the mid-1980s, when most liability insurance was impacted. At that time, manufacturers, municipalities, doctors, nurse-midwives, day-care centers, non-profit groups and many other commercial customers of liability insurance were faced with insurance rate increases of 300 percent or more. Many could not find coverage at any price. Now, once again, in 2002, the country is experiencing a new crisis, this time impacting property as well as liability coverages, with medical malpractice lines of insurance seeing rates going up 100% or more in some states.

Why is this happening?

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

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

The following Exhibit shows the national cycle at work, with premiums stabilizing for 15 years following the mid-1980s crisis.




(The 1992 data point was not a classic cycle bottom, but reflected the impact of Hurricane Andrew and other catastrophes in that year.)

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

But in the last two years, the market turned with a vengeance and the Fed cut interest rates again and again. This took place well before September 11th. The terrorist attacks sped up the price increases, collapsing two years of anticipated increases into a few months and leading to what some seasoned industry analysts see as gouging.[3] However, the increases we are witnessing are mostly due to the cycle turn, not the terrorist attack or any other cause. This is a classic economic cycle bottom.

Compounding the impact of the cycle have been misleading business and 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." Moreover, "[i]n at least one case, aggressive pricing allegedly crossed the line into fraud. … 'I don't like to hear insurance-company executives say it's the tort [injury-law] system – it's self-inflicted,' says Donald J. Zuk, chief executive of Scpie Holdings Inc., a leading malpractice insurer in California."[4]

Another insurance expert described current market problems this way:

> A quick examination of the medical malpractice insurance marketplace in the second half of 2001 might lead a dispassionate observer to conclude this segment of the insurance industry is confused, in disarray, and generally in a state of disorder. Premiums are doubling, hospital deductibles are tripling, claims-free physicians are being nonrenewed, insurers are leaving territories en masse. Simply put, the market is in chaos. … Yet, in a perverse way, the condition of the medical malpractice market is actually quite rationale and not at all surprising.
>
> 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.
>
> In a perfect world, investment income would cover any deficiencies that might exist in underwriting results and the insurers' aggressive marketing and pricing strategy would prove to be successful. Alas, we do not live in a perfect insurance world and, as competition intensified, underwriting results deteriorated. Regardless of the level of risk management intervention, proactive claims management, or tort reform, the fact remains that if insurance policies are consistently underpriced, the insurer will lose money.
>
> Clearly a business cannot continue operating in this fashion indefinitely. Indeed, this has been the case for such long time writers of professional liability insurance as Frontier, Reliance, and P.I.E Mutual. These companies, who suffered through several years of weakening performance, have been liquidated or are otherwise inactive.
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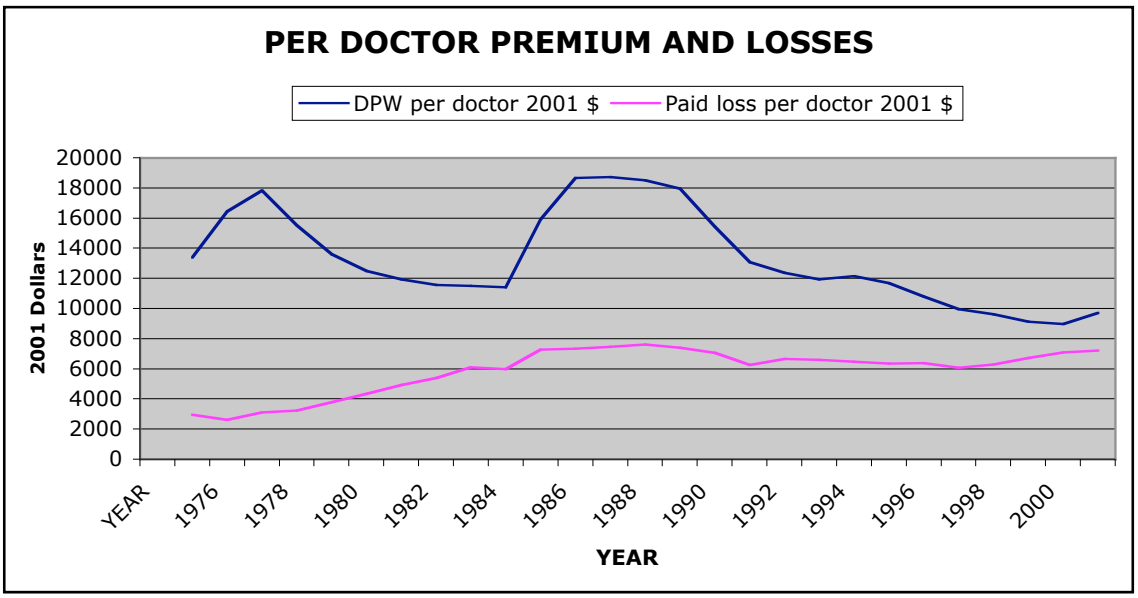
> …
>
> In August 2001, the list of impaired medical malpractice insurers got longer as the Pennsylvania Department of Insurance placed PHICO under state rehabilitation. PHICO,

> one of the ten largest writers of medical malpractice insurance, has been one of the more aggressive underwriters during the late 1990s. The company has seen its surplus decrease dramatically over the past year and half from almost $200 million to under $10 million. Regulatory intervention was necessary as it became obvious PHICO's premiums had been inadequate to cover losses.[5]

The following chart shows that since 1975, medical malpractice paid claims per doctor have tracked medical inflation very closely (slightly higher than inflation from 1975 to 1985 and flat since). In other words, payouts have risen almost precisely in sync with medical inflation. These data confirm that neither jury verdicts nor any other factor affecting total claims paid by insurance companies that write medical malpractice insurance have had much impact on the system's overall costs over time.

While payouts closely track medical inflation, medical malpractice premiums are quite another thing. They do not track costs or payouts in any direct way. Since 1975, the data show that in constant dollars, per doctor written premiums — the amount of premiums that doctors have paid to insurers — have gyrated almost precisely with the insurer's economic cycle, which is driven by such factors as insurer mismanagement and changing interest rates, not by lawsuits, jury awards, the tort system or other causes.




**Sources:** A.M. Best and Co. special data compilation for AIR, reporting data for as many years as separately available; U.S. Bureau of the Census, 1975 (2001 Estimated)[6]; Inflation Index: Bureau of Labor Statistics, 1975 (1985 estimated). **Definitions:** "DPW" or "Direct Premiums Written" is the amount of money that insurers collected in premiums from doctors during that year. "Paid losses" is what insurers actually paid out that year to people who were injured —all claims, jury awards and settlements —plus what insurance companies pay their own lawyers to fight claims.[7]

**Terrorizing States – Circa 1980s**

Threats and intimidation by reinsurers were an additional driving force behind the liability insurance "crisis" of the mid-1980s. Evidence gathered by over a dozen state attorneys general for an anti-trust class action filed in 1988, and settled in 1995, found that a number of insurance companies had helped cause the insurance "crisis" by restricting coverage to commercial customers and raising prices, creating an atmosphere intended to coax states into enacting "tort reform."[8] As John J. Byrne, Chairman and Chief Executive Officer of Geico Corp., put it, "[T]he goal is to withdraw [from the market] and let the pressure for reform build in the courts and in the state legislatures."[9]

Reinsurers were in the middle of it. In fact, according to the anti-trust complaint, Lloyd's of London became the locus of meetings and discussions for a coordinated industry effort to raise commercial insurance rates, abandon certain lines of coverage, change the standard terms of coverage used by the majority of the industry and enact "tort reforms."[10] To reach these goals, reinsurers misled U.S. public officials about reasons for rate hikes and policy cancellations and their commitment to the U.S. market.

Some of the threats directed at lawmakers were quite brash. In 1985, attorney Jeff Johnson of the U.S. law firm LeBoeuf, Lamb, Leiby and MacCrae[11] – Lloyd's U.S. counsel – told Alaska state legislators:

> If you change your tort laws in Alaska, you will have a market here when the rest of the United States will not. Lloyd's is pulling out of the United States as a reinsurer – they have already pulled out of Connecticut, New York and New Jersey – and they're continuing to pull out of more states.[12]

As a result, Alaska's Director of Insurance, John George, proceeded to tell Alaska's Defense Council, "Lloyd's is threatening to pull out of the United States, in fact they are pulling out of the States one by one, but they will stay in Alaska if we enact tort reform. If we all work together we might be able to steam roller this legislation."[13] (Alaska responded by enacting a broad "tort reform" bill.)

Despite its threats, Lloyd's never pulled out of the United States. And, within two years, desperately in need of U.S. business, Lloyd's representatives began attempting to smooth over any evidence of withdrawal and minimize their earlier intimidation of U.S. companies and public officials.[14]

**The Last Medical Malpractice Insurance "Crisis" –**
**The Influence of Reinsurers and Other Industry Practices**

Medical malpractice is one line of insurance that reinsurers historically have targeted for rate hikes. According to Director of Insurance for the Consumer Federation of America J. Robert Hunter, when he was Federal Insurance Administrator in the 1970s, a group of insurance companies in the medical malpractice line told him that Lloyd's had just doubled its reinsurance rates while supplying no data to justify this increase.[15]

The influence of reinsurers over rates has been particularly effective even over doctor-owned mutual insurance companies, which account for more than half the medical liability insurance in this country and should be independent of the profit considerations that motivate pricing decisions by the rest of the industry.

For example, in 1985 testimony before the Maryland Governor's Task Force on Maryland Mutual Society's request for a 70 percent rate increase for OB/GYNs (when a 10 percent reduction was justified), the company's president stated, "In order to keep [reinsurers'] participation on cover we had to accede to some strong suggestions from the reinsurers to beef up the rate charged to the OB's and it might be relevant to point out Med Mutual is...the only company in the state writing OB's."[16]

In 1987, after heavy lobbying by the Medical Mutual Society, Maryland's legislature passed a bill to limit collateral source payments in medical malpractice cases. According to Maryland Delegate Lawrence Wiser, in early August 1987, John Spinella, then of Medical Mutual, was asked why there was little rate reduction as a result of the new collateral source law. Spinella replied that there would not be much rate impact because Medical Mutual still had to pay the same premiums to their London reinsurers.[17]

In Arizona in April 1987, the Mutual Insurance Company of Arizona (MICA) announced medical malpractice rate increases averaging 36 percent across the board, with some as high as 50 percent, despite a whopping $38 million surplus, up 23 percent from 1985. MICA said the surplus was needed to maintain a 1:1 premium/surplus ratio, which it claimed was required by the Arizona Department of Insurance (DOI). DOI Director Dave Childers, however, denied that his department had ever required such a premium/surplus ratio.[18]

Six months later, during a subcommittee hearing of the Governor's Committee in Medical Malpractice Insurance in Arizona, Woody Beckman, MICA's actuary, implicated the reinsurance industry as responsible for both the high surplus and the premium increases. According to task force member Jim Roush, Staff Director of Fairness and Accountability in Insurance Reform, "There were...several legislators in attendance who remember, as I do, that it was a whole new defense of the surplus and certainly the first time any of us had heard of any linkage to the reinsurance market…."[19]

During the liability insurance "crisis" of the mid-1980s, numerous studies, including those conducted by the National Association of Attorneys General[20] and state commissions in New Mexico, Michigan and Pennsylvania[21], confirmed that the "crisis" was not caused by the legal

system but rather by the insurance cycle and mismanaged underwriting by the insurance industry. Even the insurance industry admitted this internally. In 1986, Maurice R. Greenberg of American International Group told an insurance audience in Boston that the industry's problems were due to price cuts taken "to the point of absurdity" in the early 1980s. Had it not been for these cuts, Greenberg said, "[T]here would not be 'all this hullabaloo' about the tort system."[22]

As *Business Week* magazine also explained a January 1987 editorial:

> Even while the industry was blaming its troubles on the tort system, many experts pointed out that its problems were largely self-made. In previous years the industry had slashed prices competitively to the point that it incurred enormous losses. That, rather than excessive jury awards, explained most of the industry's financial difficulties.[23]

A few years after the mid-1980s insurance crisis, the insurance cycle flattened out, rates stabilized and availability improved everywhere. This had nothing to do with tort law restrictions enacted in particular states, but rather with modulations in the insurance cycle everywhere. Therefore, it should come as no surprise that a 1999 Center for Justice & Democracy study, *Premium Deceit – the Failure of "Tort Reform" to Cut Insurance Prices,* found that enactment of laws that restrict injured patients' rights to go to court has not succeeded in lowering insurance costs or rates.

*Premium Deceit* is the first-ever look at 14 years of property/casualty insurance price trends nationwide. Its actuarial analysis was again conducted by J. Robert Hunter, who called *Premium Deceit* "the most extensive review of insurance rate activity in the wake of the 'liability insurance crisis' of the mid-1980s ever undertaken. It was designed to test the impact on liability insurance rates of 'tort reforms' enacted in reaction to the liability insurance crisis of the mid-1980s, and in the years since."

Hunter said, "Despite years of claims by insurance companies that rates would go down following enactment of tort reform, we found that tort law limits enacted since the mid-1980s have not lowered insurance rates in the ensuing years. States with little or no tort law restrictions have experienced approximately the same changes in insurance rates as those states that have enacted severe restrictions on victims' rights." In other words, laws that restrict the rights of injured consumers to go to court do not produce lower insurance costs or rates and insurance companies that claim they do are severely misleading this country's lawmakers.

Moreover, spokespeople for national "tort reform" organizations admitted in published statements following the release of *Premium Deceit* that lawmakers who enact "tort reforms" should not expect insurance rates to drop. Specifically, when asked to respond to *Premium Deceit,* Sherman Joyce, president of the American Tort Reform Association (ATRA), told the publication *Liability Week,* "We wouldn't tell you or anyone that the reason to pass tort reform would be to reduce insurance rates."[24] Victor Schwartz, ATRA's General Counsel and one of the principal "tort reform" lobbyists in Washington on behalf of business interests, told *Business Insurance* that while he thought some severe "tort reform" measures could reduce insurance rates, he said when pressed that, "more importantly … many tort reform advocates do not

contend that restricting litigation will lower insurance rates, and 'I've never said that in 30 years.'"[25]

And in a startling March 13, 2002 admission, the American Insurance Association (AIA), a major insurance industry trade group, said lawmakers who enact "tort reform" should not expect insurance rates to drop. Specifically, an AIA press release, evidently issued to critique *Premium Deceit,* led with an astounding face-saving pronouncement: "[T]he insurance industry never promised that tort reform would achieve specific premium savings."

**The Problem with Malpractice is Malpractice**

There is no doubt that deaths and injuries due to medical malpractice are substantial. In late 1999, the National Academy of Sciences Institute of Medicine (IOM) published *To Err is Human; Building a Safer Health System.* The study makes some striking findings about the poor safety record of U.S. hospitals due to medical errors.[26] For example:

- Between 44,000 and 98,000 deaths occur each year in U.S. hospitals due to medical errors, the higher figure extrapolated from the 1990 Harvard Medical Practice study of New York hospitals. Even using the lower figure, more people die due to medical errors than from motor vehicle accidents (43,458), breast cancer (42,297) or AIDS (16,516).

- These figures underestimate the magnitude of the medical malpractice problem, since hospital patients represent only a small percentage of the total population at risk. Not included, for example, are errors at outpatient surgical centers, physician offices and clinics.

- The cost of medical errors is huge. Total national costs (lost income, lost household production, disability and health care costs) are estimated to be between $17 billion and $29 billion each year, of which health care costs represent over one-half.

Following the IOM study, several newspapers ran extensive series on the degree and cost of malpractice in their states. For example, in March 2000, a *New York Daily News* week-long investigative series found that "hundreds of New York State doctors, dentists and podiatrists – ranging from modest practitioners to prominent surgeons – have amassed extensive hidden histories of malpractice yet continue to treat patients." Moreover, "making even three malpractice payments is rare – only 1% of the nation's doctors have crossed that line, according to the national database. But those doctors account for 24% – or $5.6 billion – of the money paid to aggrieved patients…. The effect of failing to crackdown on the tiny percentage of doctors with the worst malpractice records is stunning, because they are a powerful driving force behind medical misfeasance nationwide."

Please note that in 1986, the *Orlando Sentinel* ran a major investigative series on this same topic, reporting that "3 percent of doctors were responsible for 48 percent of the malpractice claims pad in the state between 1975 and 1984. One doctor had 34 paid claims. Four others had 10 or more paid claims."

These conclusions are similar to those found by Public Citizen's Health Research Group in its book *20,125 Questionable Doctors*.[27] The group found that only one-half of 1 percent of 770,320 licensed medical doctors face any serious state sanctions each year. "Too little discipline is still being done," the report said. "2,696 total serious disciplinary actions a year, the number state medical boards took in 1999, is a pittance compared to the volume of injury and death of patients caused by negligence of doctors…. Though it has improved during the past 15 years, the nation's system for protecting the public from medical incompetence and malfeasance is still far from adequate."

Despite the amount of medical negligence currently harming patients in this country, very few victims file suit and those who do often have a very difficult time winning their cases. The 1990 Harvard Medical Practice study found that eight times as many patients are injured by medical malpractice as ever file a claim; 16 times as many suffer injuries as receive any compensation.[28] Moreover, defendants now prevail in 76.6 percent of all medical malpractice trials, according to the Bureau of Justice Statistics and the National Center for State Courts.[29]

Moreover, nationally, insurance companies are paying victims of medical negligence on average *under $32,000* and have been for the last decade.[30] Even assuming a 15 percent increase over the next few years, the averages would stay below $35,000 per claimant. In fact, total insurance payouts to *all claimants* have hovered between $2.5 billion and $4 billion per year. By comparison, Americans spend at least twice that much – about $8 billion – on dog food each year. Moreover, medical malpractice costs, as a percentage of national health care expenditures, are now at an all time low, 0.55 percent.

The above analysis, conducted for the Center for Justice & Democracy by actuary J. Robert Hunter, Director of Insurance for the Consumer Federation of America, examined year 2000 insurance data, the most recent available from the National Association of Insurance Commissioners and A.M. Best and Co. Hunter, former Texas Insurance Commissioner and Federal Insurance Administrator, concludes, "Medical malpractice insurance is amazing value, considering that it covers all medical injuries for about one-half of one percent of health system costs."

## A Word About Defensive Medicine Costs

There is universal agreement that at most a very small portion of health care costs result from "defensive medicine." In 1994, the Office of Technology Assessment was asked, initially by proponents of sweeping malpractice tort restrictions, to study the issue. This much-anticipated landmark study by the OTA, entitled *Defensive Medicine and Medical Malpractice* (July 1994), completely undermined the credibility of claims that "tort reform" will significantly reduce "defensive medicine." The OTA found that:

- Only "a relatively small proportion of all diagnostic procedures – certainly less than 8 percent – is likely to be caused primarily by conscious concern about malpractice liability risk." The OTA also stressed that this figure actually "overestimates the rate" of "defensive" medicine because it "is based on physicians' responses to hypothetical clinical scenarios that were designed to be malpractice sensitive."

- Most physicians who order "aggressive diagnostic procedures . . . do so primarily because they believe such procedures are medically indicated, not primarily because of concerns about liability."

- The effects of traditional "tort reforms" – particularly caps on damages and amendments to the collateral source rule – on defensive medicine "are likely to be small."

- "[P]hysicians consistently overestimate their own and their colleagues' risk of being sued."

- Defensive medicine "may benefit patients."

- "It is impossible to accurately measure the overall level and national cost of defensive medicine."

- "Health care reform may change financial incentives toward doing fewer rather than more tests and procedures. If that happens, concerns about malpractice may act to check potential tendencies to provide too few services."

**Serious Solutions to Solve This "Crisis" and Prevent Future Ones**

Listen to anyone other than the insurance and medical lobbies, or politicians and agencies beholden to them, and the fallacy of enacting "tort reform" to solve a self-inflicted insurance problem becomes clear.

- **National Association of Insurance Commissioners.** In September 2002, the National Association of Insurance Commissioners (NAIC) agreed to examine the current insurance "crisis" as a self-inflicted problem created by the insurers. The NAIC appointed a Market Conditions Working Group "to coordinate the evaluation of AIR [Americans for Insurance Reform]'s recommendations and to monitor the most distressed lines of business, formulate solutions, and propose regulatory responses." AIR has requested insurance departments to undertake 14 different audits, investigations and reforms to control excessive insurance prices, including an immediate freeze on malpractice and homeowners' rates and regulation of excessive rates.

- **National Academy of State Health Policy.** A July 2002 study by the National Academy of State Health Policy (funded by the Robert Wood Johnson Foundation) found that "[t]he move toward more restrictive tort reform does not address the complexity of the problem. Previous rounds of tort reform that followed the malpractice insurance crises of the 1970s and 1980s have not succeeded in preventing periodic and dramatic rises in insurance premiums."[31]

- **U.S. General Accounting Office.** In July 2002, ten members of the U.S. House of Representatives requested a U.S. General Accounting Office (GAO) investigation of the

insurance industry's responsibility for creating nationwide medical malpractice insurance problems for doctors, including how the insurers' declining investment income and "insurance industry practices" have contributed to skyrocketing insurance rates for doctors over the last few months. This study is ongoing.

There has been a burgeoning interest in the formation of captive insurance companies and risk retention groups for doctors, hospitals, nursing homes and other medical groups in states that have lost carriers. In Pennsylvania, a new medical malpractice "reciprocal exchange" insurer has applied to do businesses in the state. This is similar to Miix Group Advantage Insurance Co., a new physician-sponsored company proposed in New Jersey.

Moreover, some state officials have already moved to freeze rates. In July, New York State's insurance department rejected a requested 8% rate increase for that state's largest medical malpractice insurer, saying the company did not need it. In Pennsylvania in August 2002, Pennsylvania's Attorney General urged the state insurance commissioner to suspend the up to 48% medical malpractice insurance rate increase for Pennsylvania's joint underwriting authority.

At a minimum, there must be a full and thorough investigation of the insurance companies' data to determine if there are errors and over-reserving in the data.

In particular, this Task Force needs answers to the following questions:

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

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

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

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

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

Other specific reforms that would help ease the "crisis" include:

- **Regulation of excessive pricing.** One cause of the cycle is the lack of regulatory action to end excessive and inadequate rates during the different phases of the cycle.

- **Requiring that risks with poorer experience pay more than good risks in lines of insurance where such methods are not in use today.** For example, Florida should require medical malpractice insurers to use claims history as a rating factor, and to give

that factor significant weight. Auto insurers use an individual's driving record as a rating factor; workers' compensation insurers use the employer's loss experience as a rating factor– so-called "experience mod." Malpractice insurers should do the same. In addition, you should require all medical malpractice insurers to offer all "good" doctors– *i.e.,* all doctors meeting an objective definition of eligibility based on their claims history, their amount of experience and perhaps other factors – the lowest rate.

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

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

**Conclusion**

In a March 5, 1995 *New York Times* article, Dr. Wayne Cohen, then-medical director of Bronx Municipal Hospital, said, "The city was spending so much money defending obstetrics suits, they just made a decision that it would be cheaper to hire people who knew what they were doing."[32] In a somewhat obscure way, Dr. Cohen actually heralded one of the most important functions of lawsuits and the civil justice system: deterring unsafe practices. Numerous hospital and medical procedures have been made safer as a result of lawsuits. These include anesthesia procedures, catheter placements, drug prescriptions, hospital staffing levels, infection control, nursing home care and trauma care, all of which are documented in the Center for Justice & Democracy study, *Lifesavers: CJ&D's Guide to Lawsuits that Protect Us All*.

Indeed, our goal must be to reduce medical negligence. Moreover, effective insurance reforms are the only way to stop the industry from abusing its enormous economic influence, which it uses to promote a legislative agenda that bilks taxpayers and severely hurts the American public. Laws and proposals that increase the obstacles sick and injured patients face in the already difficult process of prevailing in court are certainly the wrong way to respond to any medical malpractice insurance "crisis." Tort restrictions only reduce the financial incentive of institutions like hospitals and HMOs to operate safely, when our objectives should be deterring unsafe and substandard medical practices while safeguarding patients' rights.

# Major Tort Restrictions Enacted in Medical Malpractice Cases, 1985-1999

Alabama
Pre-1985: collateral source
87: med mal cap (but declared unconstitutional in 91)
87: punitive cap (but declared unconstitutional in 93)
87: collateral source (but declared unconstitutional in part in 96)

Alaska
86: cap, non-economic
86: joint and several liability
86: collateral source rule
88: joint and several liability (ballot initiative)
97: cap, all damages
97: punitive cap
97: prejudgment interest

Arizona
Pre-1985: med mal collateral source
87: joint and several
89: med mal structured settlements (but declared unconstitutional in 94)

Arkansas
Pre-1985: medical malpractice structured settlements

California
Pre-1985: med mal cap, noneconomic; med mal collateral source; med mal contingency fees; med mal structured settlements
86: joint and several liability (ballot initiative)

Colorado
86: cap, noneconomic
86: joint and several liability
86: punitive cap
86: collateral source
88: med mal cap, all damages
88: med mal statute of repose
88: med mal structured settlements
92: med mal collateral source

Connecticut
85: med mal collateral source
86: joint and several (i.e. proportional) liability
86: contingency fees

Delaware
Pre-1985: collateral source; med mal contingency fees; med mal structured settlements

District of Columbia
Pre-1985: collateral source

Florida
86: joint and several liability
86: collateral source
86: med mal structured settlements
86: contingency fees
86 : punitive cap
88: cap noneconomic (but declared unconstitutional in 91)
88: med mal cap, noneconomic (depending on arbitration)

Georgia
87: punitive cap
87: joint and several liability

Hawaii
86: cap, noneconomic
86: joint and several liability (except medical products)
86: collateral source (liens)

Idaho
87: cap, noneconomic
87: joint and several liability
87: structured settlements
90: collateral source

Illinois
Pre-1985: med mal collateral source
85: medical malpractice structured settlements
85: med mal contingency fees
95: cap, noneconomic (but declared unconstitutional in 97)
95: joint and several liability (but declared unconstitutional in 97)
95: punitive cap (but declared unconstitutional in 97)

Indiana
Pre-1985: joint and several liability
86: collateral source
93: med mal cap, all damages
93: med mal contingency fee
95: punitive cap

Iowa
Pre-1985: joint and several liability; med mal collateral source
86: structured settlements
87: collateral source
87: prejudgment interest
87: structured settlements
97: joint and several liability
97: prejudgment interest

Kansas
85: med mal punitive cap (but expired in 88)
86: med mal cap (but declared unconstitutional in 88)
86: med mal structured settlements (but declared unconstitutional in 88)
87: cap, noneconomic
87: punitive cap
88: collateral source (but declared unconstitutional in 93)

Kentucky
88: joint and several liability (but codified common law rule)
88: collateral source (but declared unconstitutional in 95)

Louisiana
Pre-1985: med mal cap; med mal structured settlements (Patients Comp. fund); joint and several liability
87: joint and several liability
87: prejudgment interest
96: joint and several liability

Maine
85: med mal structured settlements
85: med mal contingency fees
88: prejudgment interest
89: med mal collateral source

Maryland
Pre-1985: collateral source
86: cap, noneconomic
86: structured settlements

Massachusetts
86: med mal cap, noneconomic
86: med mal collateral source
86: med mal contingency fees

Michigan
86: med mal cap, noneconomic
86: collateral source
86: structured settlements
86: prejudgment interest
87: joint and several liability
93: med mal cap, noneconomic
95: joint and several liability

Minnesota
86: cap, noneconomic (but repealed in 90)
86: collateral source
86: prejudgment interest
88: joint and several liability

Mississippi
89: joint and several liability

98: med mal statute of repose

Missouri
86: med mal cap, noneconomic
86: med mal structured settlements
87: joint and several liability
87: collateral source

Montana:
87: joint and several liability (but declared unconstitutional in 94)
87: collateral source
95: med mal cap, noneconomic
95: med mal structured settlements
97: joint and several liability

Nebraska
Pre-1985: collateral source; med mal cap (cap increased in 92)
86: prejudment interest (but improved prior standard)
92: joint and several liability (but improved prior standard)

Nevada
Pre-1985: med mal collateral source
87: joint and several liability
89: punitive cap

New Hampshire
86: cap, noneconomic (but declared unconstitutional in 91)
86: punitive abolished
89: joint and several liability
95: prejudgment interest

New Jersey
Pre-1985: contingency fees
87: joint and several liability
87: collateral source
95: punitive cap
95: joint and several liability

New Mexico
87: joint and several liability (but codified common law)
92: med mal structured settlement
92: med mal cap (except punitives)

New York
86: joint and several liability
86: collateral source
86: structured settlements
86: med mal contingency fees

North Carolina
95: punitive cap

North Dakota
87: joint and several liability
87: collateral source
87: structured settlements
93: punitive cap
95: med mal cap, noneconomic

Ohio
87: joint and several liability
87: structured settlements
96: cap, noneconomic
96: joint and several liability
96: punitive cap
96: collateral source
96: prejudgment interest

Oklahoma:
86: prejudgment interest
95: punitive cap

Oregon
87: cap, noneconomic
87: joint and several liability
87: med mal punitives abolished against doctors
87: collateral source
95: joint and several liability

Pennsylvania
Pre-1985: med mal collateral source
96: med mal punitive cap

Rhode Island
86: med mal collateral source
87: prejudgment interest

South Carolina
Pre-1985: med mal structured settlements (Patient Comp. Fund with annual cap)

South Dakota
Pre-1985: med mal collateral source; med mal cap; noneconomic
86: med mal cap, economic (but declared unconstitutional 96)
86: med mal structured settlements
87: joint and several liability

Tennessee
Pre-1985: med mal collateral source

Texas
87: med mal cap (but declared unconstitutional in 88, although allowed for wrongful death, 90)
87: joint and several liability (except environmental)

87: punitive cap
87: prejudgment interest
95: joint and several liability
95: punitive cap

Utah
85: med mal collateral source
86: med mal cap, noneconomic
86: joint and several liability
86: med mal structured settlements

Vermont:
Pre-85: joint and several liability

Virginia
Pre-1985: med mal cap (although cap raised in 83 and 99)
87: med mal (children injured at birth, no right to sue, no noneconomic or punitives)
87: punitive cap

Washington
Pre-1985: punitive cap; med mal collateral source
86: cap, all damages (but declared unconstitutional in 88)
86: joint and several liability
86: structured settlements

West Virginia
86: med mal cap, noneconomic
86: med mal joint and several liability

Wisconsin
Pre-1985: med mal (Patient Comp. Fund)
86: med mal cap, noneconomic (but expired 90)
86: med mal contingency fees
95: med mal cap
95: joint and several liability
95: med mal structured settlements
95: med mal collateral source

Wyoming
86: joint and several liability

# *NOTES*

[11] "'Tort Reform' a Fraud, Insurers Admit," and "Tort Reform Will Not Reduce Insurance Rates, Say 100+ Florida Insurers," National Insurance Consumer Organization (1986).

[2] Hunter, J. Robert, Joanne Doroshow, *Premium Deceit – the Failure of "Tort Reform" to Cut Insurance Prices,* Center for Justice & Democracy (1999).

[3] "…there is clearly an opportunity now for companies to price gouge – and it's happening…. But I think companies are overreacting, because they see a window in which they can do it." Jeanne Hollister, consulting actuary, Tillinghast-Towers Perrin, quoted in, "Avoid Price Gouging, Consultant Warns," *National Underwriter*, January 14, 2002.

[4] Christopher Oster and Rachel Zimmerman, "Insurers' Missteps Helped Provoke Malpractice 'Crisis,'" *Wall Street Journal*, June 24, 2002.

[5] Charles Kolodkin, Gallagher Healthcare Insurance Services, "Medical Malpractice Insurance Trends? Chaos!" September 2001, http://www.irmi.com/expert/articles/kolodkin001.asp.

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

[7] "Paid losses" are a far more accurate reflection of actual insurer payouts than what insurance companies call "incurred losses." Incurred losses are not actual payouts. They include payouts but also reserves for possible future claims – *e.g.,* insurers' estimates of claims that they do not even know about yet. While incurred losses do exhibit more of a cyclical pattern, observers know that this is because in hard markets, as we are currently experiencing, insurers will increase reserves as a way to justify price increases. In fact, the current insurance "crisis" rests significantly on a jump in loss reserves in 2001. Historically, reserves have been later "released" to profits during the "softer" market years. For example, according to a June 24, 2002, *Wall Street Journal* front page investigative article, St. Paul, which until 2001 had 20 percent of the national med mal market, pulled out of the market after mismanaging its reserves. The company set aside too much money in reserves to cover malpractice claims in the 1980s, so it "released" $1.1 billion in reserves, which flowed through its income statements and appeared as profits. Seeing these profits, many new, smaller carriers came into the market. Everyone started slashing prices to attract customers. From 1995 to 2000, rates fell so low that they became inadequate to cover malpractice claims. Many companies collapsed as a result. St. Paul eventually pulled out, creating huge supply and demand problems for doctors in many states. Christopher Oster and Rachel Zimmerman, "Insurers' Missteps Helped Provoke Malpractice 'Crisis,'" *Wall Street Journal*, June 24, 2002.

[8] *In re Insurance Antitrust Litigation*, MDL No. 767, No. C-88-1688 [CAL] (N.D. Cal.); *The State of Texas v. Insurance Services Office, Inc., et al,* No. 439089 (Tex. Dist. Ct., Travis Co., 53rd Jud. Dist., filed March 22, 1998). *See also,* "Final Approval Given To Insurance Antitrust Settlement," *Mealey's Litigation Reports,* April 18, 1995; "Ten States Announce They Will Join Antitrust Suits," *Insurance Antitrust & Tort Reform Report,* June 15, 1986; Joanne Doroshow and Adrian Wilkes, *Goliath: Lloyd's of London in the United States*, Center for Study of Responsive Law (1988), text accompanying n. 74-77; pp. 69-95.

[9] *Journal of Commerce,* June 18, 1985.

[10] *In re Insurance Antitrust Litigation*, MDL No. 767, No. C-88-1688 [CAL] (N.D. Cal.); *The State of Texas v. Insurance Services Office, Inc., et al,* No. 439089 (Tex. Dist. Ct., Travis Co., 53rd Jud. Dist., filed March 22, 1998).

[11] LeBoeuf, Lamb, Greene and MacCrae is the firm's current name.

[12] *The Liability Insurance Crisis,* Hearings Before the Subcomm. On Economic Stabilization of the House Comm. On Banking, Finance and Urban Affairs, 99th Cong., 2nd Sess. 83 (1986)(Testimony of J. Robert Hunter)(Exh. I, sheet 3)(Excerpt from Report of Casualty Insurance Colloquium held for Alaska State Legislators by the Insurance Industry, September 17, 1985)(Statement by Jeff Johnson).

[13] Summary of Casualty Insurance Colloquium held for Alaska State Legislators by the Insurance Industry (September 17, 1985)(Statement from summary of presentation of John George, Director of Insurance, State of Alaska).

[14] *See*, *e.g.*, "Lloyd's Forecast is Bullish," *Journal of Commerce,* September 8, 1987.

[15] *See*, Joanne Doroshow and Adrian Wilkes, *Goliath: Lloyd's of London in the United States*, Center for Study of Responsive Law (1988), pp. 74-75.

[16] *The Liability Insurance Crisis,* Hearings Before the Subcomm. On Economic Stabilization of the House Comm. On Banking, Finance and Urban Affairs, 99th Cong., 2nd Sess. 83 (1986)(Testimony of J. Robert Hunter) (Exh. I, Sheet 1).

[17] Telephone Interview by Joanne Doroshow with Delegate Lawrence Wiser, October 13, 1987.

[18] Letter from Jim Roush, Staff Director, Fairness and Accountability in Insurance Reform to Joanne Doroshow, dated October 8, 1987.

[19] *Ibid.*

[20] Francis X. Bellotti, Attorney General of Massachusetts, et al., *Analysis of the Causes of the Current Crisis of Unavailability and Unaffordability of Liability Insurance* (Boston, MA: Ad Hoc Insurance Committee of the National Association of Attorneys General, May 1986).

[21] *See*, *e.g.*, New Mexico State Legislature, *Report of the Interim Legislative Workmen's Compensation Comm. on Liability Insurance and Tort Reform*, November 12, 1986; Michigan House of Representatives, *Study of the Profitability of Commercial Liability Insurance*, November 10, 1986; Insurance Comm. Pennsylvania House of Representatives, *Liability Insurance Crisis in Pennsylvania*, September 29, 1986.

[22] Greenwald, "Insurers Must Share Blame: AIG Head," *Business Insurance*, March 31, 1986.

[23] "What Insurance Crisis?" *Business Week*, January 12, 1987.

[24] "Study Finds No Link between Tort Reforms And Insurance Rates," *Liability Week*, July 19, 1999.

[25] Michael Prince, "Tort Reforms Don't Cut Liability Rates, Study Says," *Business Insurance*, July 19, 1999.

[26] Kohn, Corrigan, Donaldson, Eds., *To Err is Human; Building a Safer Health System*, Institute of Medicine, National Academy Press: Washington, DC (1999).

[27] Sidney Wolfe et al., *20,125 Questionable Doctors*, Public Citizen Health Research Group, Washington, DC (2000).

[28] Harvard Medical Practice Study, *Patients, Doctors and Lawyers: Medical Injury, Malpractice Litigation, and Patient Compensation in New York* (1990).

[29] *Examining the Work of State Courts, 2001; A National Perspective from the Court Statistics Project* (2001), p. 94; "Tort Trials and Verdicts in Large Counties, 1996," U.S. Department of Justice, Office of Justice Programs, Bureau of Justice Statistics, NCJ-179769 (August 2000), p. 4.

[30] Memo from Joanne Doroshow to Interested Persons with attached spreadsheet prepared by J. Robert Hunter, Director of Insurance, Consumer Federation of America, November 14, 2001.

[31] *The Medical Malpractice Insurance Crisis: Opportunity for State Action,* National Academy of State Health Policy (July 2002).

[32] Dean Baquet and Jane Fritsch, "New York's Public Hospitals Fail, and Babies Are the Victims," *New York Times,* March 5, 1995.