

# The Whole Truth About Medical Malpractice and Insurance

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Illinois Trial Lawyers Association  
401 West Edwards Street  
Springfield, IL 62704  
800-252-8501  
[www.iltla.com](http://www.iltla.com)

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## Executive Summary

In 2005, Illinois enacted an arbitrary \$500,000 cap on the total amount of non-economic damages recoverable by patients in medical malpractice cases against doctors and an arbitrary \$1 million cap in cases against hospitals. Proponents of the cap argued that malpractice claims and verdicts were skyrocketing, driving doctors out of Illinois, and raising health care costs. These arguments were a complete fiction, and the insurance companies' own data proves the medical malpractice "lawsuit crisis" is a myth.

**Claims and payouts have been stable.** Court records show that the annual filings of malpractice lawsuits in Illinois steadily *decreased* before the enactment of the damages caps in 2005 and thereafter. The insurance companies' regulatory filings show that since 2000, both frequency and severity of malpractice claims and payouts have been stable, or even decreasing. It was necessary for the proponents of caps to resort to statistical manipulations to argue for caps. For example, before 2003, the state's largest medical malpractice insurer, ISMIE, counted a claim involving both an ISMIE-insured doctor and an ISMIE-insured medical corporation or clinic as a *single* claim. In 2003, ISMIE altered its reporting system and, for the first time ever, began to count a combined doctor/clinic claim as *two* claims. This change doubled the number of reported claims overnight. Then in 2005, in hearings before the General Assembly, ISMIE grossly overstated its expected future total payouts on claims to argue for caps — but after the cap was passed, ISMIE substantially lowered those numbers and admitted the cap had nothing to do with the change.

**The “judicial hellhole” claim is another myth.** The data show that Cook, Madison and St. Clair counties have seen the same trend of stable, if not declining, frequency and severity of medical malpractice claims.

**Insurance companies have enjoyed record profits.** Insurance company data reveals that total insurance payouts remained flat between 2000 and 2005, while malpractice insurance rates dramatically increased. The result was record insurance company profits and gold-plated compensation packages for insurance executives. ISMIE’s net income doubled in three consecutive years (2004 through 2006), and it earned a record profit of \$50.2 million in 2006. ISMIE added profits of \$40 million in 2007 and \$34 million in 2008, making it one of the most profitable carriers in the country.

**Insurance rate fluctuations are the result of market conditions.** Insurance companies have admitted that business conditions and diminished returns on financial investments – rather than malpractice claims – were responsible for the increase in insurance rates.

**Insurance reforms, not caps, will deal with excessive insurance rates.** Insurance reforms have created new competition in the insurance market and stabilized and even lowered rates. Insurance regulation superimposed upon market conditions is the only effective way to control insurance rates.

**Medical malpractice claims have had little effect on hospitals’ bottom line.** Although hospitals have asserted that they face increased numbers of claims, they have never placed their internal data in the public domain and therefore has never been independently verified. There is ample reason to be skeptical. After hospitals

submitted a selective analysis of Cook County verdicts to the General Assembly in 2005, re-analysis (which included complete verdict data) showed that noneconomic damages awards against hospitals actually *declined* from 2002-2003. Moreover, hospitals have been prospering financially and enjoying record profits, without caps having had any impact.

**Assertions of a physician “exodus” are phony.** The number of doctors in Illinois has increased every year since 1963— measured statewide in total terms, per capita, and even for specialists like neurosurgeons and OB/GYNs. Illinois’ growth in physician supply has outpaced all but one of Illinois’ thirteen neighboring states, even though most of those states have damages caps.

**The health care cost argument is phony.** Authoritative studies by independent scholars have consistently shown that medical malpractice claims and lawsuits have little or no effect on overall health care costs.

**Improved patient safety prevents malpractice lawsuits.** Medical malpractice is a leading cause of death and injury in the United States, injuring an estimated 180,000 and killing tens of thousands of Americans annually. Preventing malpractice in the first place is the best way to avoid malpractice litigation.

**History repeats itself.** Tales of a medical malpractice “crisis” were told in 1975, 1985, and 1995 – a ten-year, repeating pattern that further underscores that insurance rates are related more to the business cycle and insurance company investment income than to tort claims. In response to each tale of “crisis,” Illinois adopted arbitrary tort reform laws. Each time courts held key parts of the laws unconstitutional, and every time caps were included in the laws, they were held to be

unconstitutional. Each time bogus predictions were made that “the sky-is-falling” and that the court action would cause another “crisis,” and each time these claims were subsequently discredited. This time will prove to be no different.

## THE WHOLE TRUTH ABOUT MEDICAL MALPRACTICE AND INSURANCE

In 2005, Illinois enacted a law imposing an arbitrary cap of \$500,000 on the total amount of noneconomic damages recoverable by patients in medical malpractice cases against doctors and \$1 million in cases against hospitals. The law was passed to address allegations that malpractice claims and verdicts were out of control and were causing: (1) a spike in malpractice insurance rates; (2) a “flight” of many doctors from Illinois; (3) higher health care costs; and (4) financial problems for hospitals. Caps on damages were said to be the solution to all these problems.

But these allegations had no basis in reality, or in “Reality Medicine,” to borrow a slogan from ISMIE, the predominant malpractice insurer for doctors in Illinois.<sup>1</sup> As one scholar recently noted, “in fact almost all of the claims made to support tort reform in the area of medical malpractice are not consistent with the empirical data.”<sup>2</sup>

- The medical malpractice “lawsuit crisis” is a myth.
- Since 2000, malpractice insurance rates have dramatically increased while the frequency and severity of malpractice claims and payouts have not.
- As in the rest of the state, Cook, Madison and St. Clair counties have seen the same trend of stable, if not declining, frequency and severity of medical malpractice claims, a trend which puts the lie to libelous allegations that these counties are “judicial hellholes.”
- The dramatic increases in malpractice insurance rates in the years leading up to 2005 were not needed to pay claims, because there was no increase in claims.
- Medical malpractice insurance rate increases between 2000 and 2005 arose from insurers’ business decisions and reduced investment returns, not medical malpractice claims.
- The net result of the medical malpractice insurance rate increases was record insurance company profits and gold-plated compensation packages for insurance executives.

- Medical malpractice claims have had little effect on hospitals' bottom line.
- The assertion of a physician "exodus" is phony. The number of doctors in Illinois has increased every year since 1963- measured statewide in total terms, per capita, and for specialists like neurosurgeons and obstetricians. Illinois' growth in physician supply has even outpaced many states that have damages caps, including all but one of Illinois' thirteen neighboring states.

- Independent authoritative studies have consistently shown that medical malpractice claims have little or no effect on overall health care costs.

- Insurance reform, not lawsuit reform, is the only way to reduce excessive malpractice insurance rates. The recent decline in medical malpractice insurance rates was the result of government oversight leading to increased competition in the insurance market.

- Medical malpractice is a leading cause of death and injury in the United States, injuring over 180,000 and killing tens of thousands of Americans annually. Improved patient safety is the best way to prevent malpractice cases – by preventing malpractice in the first place.

- History repeats itself. The same cries of a medical malpractice "crisis" were also heard in 1975, 1985, and 1995 – a ten-year, repeating pattern that further underscores the fact that insurance rates are related to insurance business cycles and investment income rather than to malpractice claims. In response to each "crisis," Illinois adopted laws restricting patient rights. Each time the courts held laws unconstitutional – twice specifically holding caps unconstitutional. Each time the dire predictions that the court action would cause another crisis proved completely unfounded.

Now yet again, the Supreme Court's recent decision in *Lebron* was based upon its consistent history of rulings that non-economic damages caps are unconstitutional. The

Court observed that “we do not write today on a blank slate,”<sup>3</sup> and explained that its decision in *Best v. Taylor Machine Works* striking down non-economic damages caps in medical malpractice and other kinds of tort cases, “is as valid today as it was in 1997 and controls the disposition of the present case.”<sup>4</sup>

The Court noted that its decision also invalidated malpractice insurance reforms included in the legislation only because of the inseverability clause in the legislation which required all other parts of the law to fall with the invalid damages cap. The Court stressed that these other insurance market reforms were “deemed invalid solely on inseverability grounds, [and] the legislature remains free to reenact any provisions it deems appropriate.”<sup>5</sup> These highly effective insurance reforms should be reenacted as soon as possible.

**I. The Medical Malpractice “Lawsuit Crisis” is a Myth.**

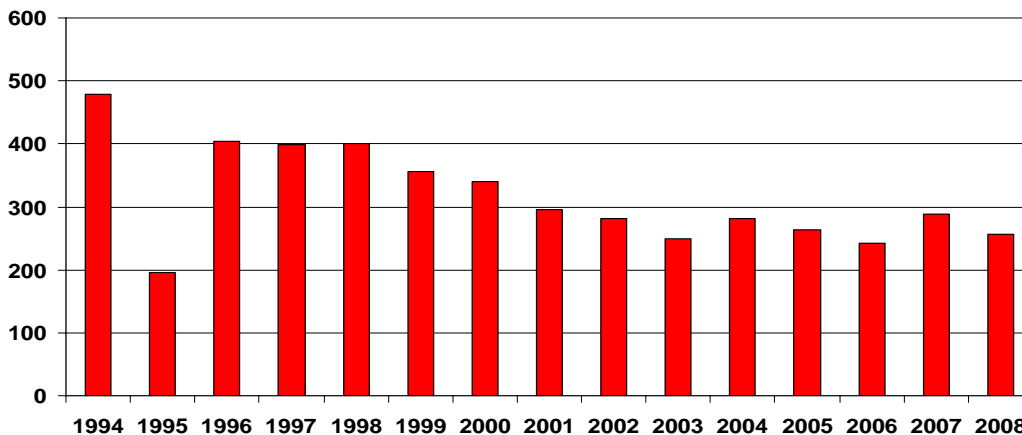
The Illinois State Medical Inter-Insurance Exchange (“ISMIE”) raised its malpractice rates by about 80 percent between 2000 and 2004 (5 percent in 2000, 12.47 percent in 2001, 15 percent in 2002, 35.2 percent in 2003, and 7.2 percent in 2004).<sup>6</sup> ISMIE blamed this on dramatic increases in “frequency” and “severity” of claims but ISMIE’s own data show the opposite – claims frequency and severity were stable or even decreasing.

**A. “Frequency” was Stable, or Even Decreasing**

“Frequency” is “insurance-speak” for the number of claims and lawsuits filed. ISMIE contended that claims frequency had doubled, a contention disproven by ISMIE’s own data. The data clearly shows that there was no material change in the frequency of claims – frequency was actually stable or even decreasing.

When the damages caps were enacted in 2005, the number of claims ISMIE had paid each year had already been generally *declining*, according to ISMIE’s own annual statements, required by law to be filed with the Department of Insurance.<sup>7</sup> In 1998, ISMIE paid a total of 400 claims, in 2000 it paid 340, and every year since then it has paid fewer than 300. By 2008, the number had fallen to 257.

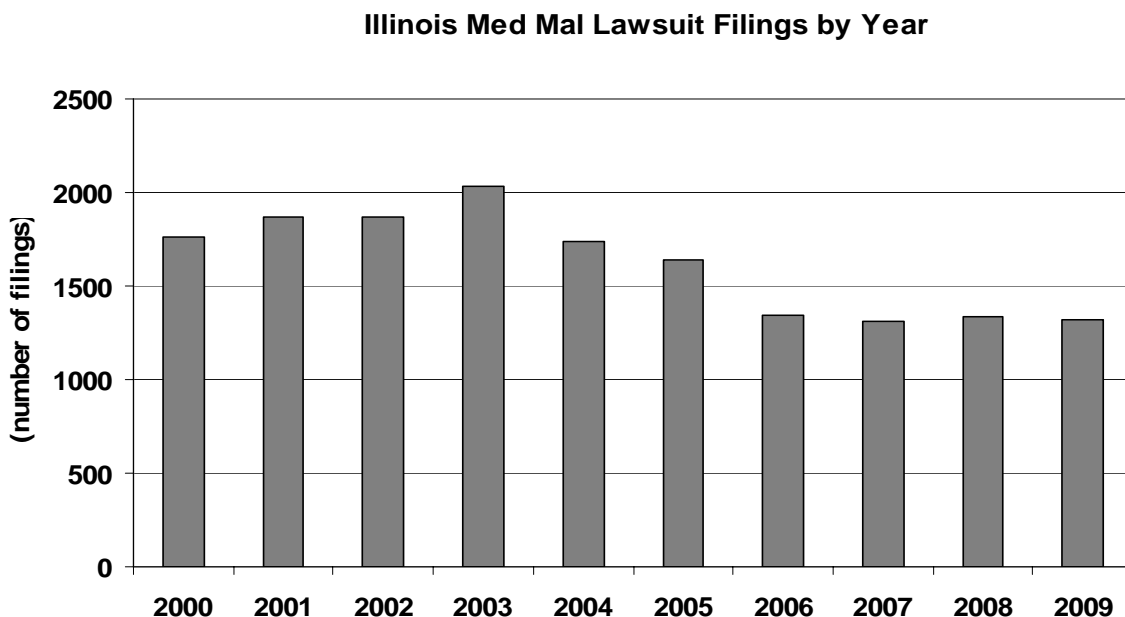
**ISMIE - Number of Claims Paid by Year**



ISMIE’s data likewise show a flat or even downward trend in the percentage of claims on which it made a payment to the plaintiff. During a Department of Insurance rate hearing later in 2005, in analyzing “the ratio of claims that are closed with an indemnity payment to total closed claims,” an actuary for ISMIE admitted under oath that historically this ratio has “been relatively flat, possibly decreasing” since 2000.<sup>8</sup>

Medical malpractice payouts have also been on the decline nationwide for years. The National Practitioner Data Bank, which tracks such payments, shows that the number of malpractice payments nationwide in 2008 was the lowest since its creation in 1990, and was the *third consecutive year* in which the number of medical malpractice payments fell to an *all-time low*.<sup>9</sup> Another report from the National Center for State Courts showed that the number of malpractice cases filed between 1996 and 2006 dropped by 8 percent.<sup>10</sup>

Court records show that the number of medical malpractice lawsuits filed in Illinois each year had been stable and then *decreasing before* the enactment of the damages caps in 2005.



Researchers at Tennessee State University found that there is no evidence to support the claim that in recent years jury verdicts in medical malpractice cases nationwide have increased significantly.<sup>11</sup> One scholar has noted “the number of medical malpractice cases being filed *per capita* has dropped over the last ten years, as have tort filings generally. Even in the states that the AMA has labeled ‘crisis states,’ the number of cases per capita has been dropping.”<sup>12</sup>

It was not until after the cap became law that ISMIE representatives admitted under oath that there *was no actual data to support its claim of an increase in frequency of claims.*<sup>13</sup> In questioning ISMIE executives at a hearing in September 2005, the Director of the Department of Insurance noted that “[f]rom, say, 2003 to 2004, the data doesn’t show an increase in frequency or severity,” and repeatedly pressed ISMIE for its explanation of the premium increases.<sup>14</sup> Under oath, high-level ISMIE representatives were completely incapable of answering a simple question: why had the number of “claims” reported to the Department more than doubled from 2002 to 2003, around the time of ISMIE’s 35 percent increase in insurance premiums?<sup>15</sup>

ISMIE’s Vice President of Claims sent the Director a delayed but damning response. He stated that he was “stunned” by the question and ISMIE’s inability to answer it at the hearing. He explained that *before 2003*, a claim or lawsuit involving both an ISMIE-insured doctor and the doctor’s ISMIE-insured medical corporation (or clinic) had always been reported as *one* claim. Starting in 2003, ISMIE changed its reporting system and, for the first time ever, began to report a claim against both a doctor and a clinic as *two* claims.<sup>16</sup> Such double-counting accounts for much of the “increase” in claims reported by ISMIE to the Department in 2003 and thereafter. The abrupt and covert change ISMIE made in 2003 to its longstanding practice of reporting combined doctor/clinic claims as a *single* claim had

provided it with a phony yet dramatic “increase” in claims—one of its two stated reasons for its increase in premiums.

ISMIE employed other deceptive claim-counting practices to concoct the myth of a “crisis.” ISMIE’s counting system registers five separate claims if five ISMIE doctors are sued in one case.”<sup>17</sup> If thereafter a jury determines that one of those doctors is guilty of malpractice and the other four are not, ISMIE deems 80 percent of the “claims” in that lawsuit “closed without payment” to the patient and without merit. Such a system inflates both the number of “claims” and the number of supposedly non-meritorious claims. Prominent advocates for limiting patients’ rights, such as well-known tort-reform advocate and American Tort Reform Association (ATRA) general counsel Victor Schwartz, admit that frivolous medical malpractice lawsuits are uncommon, “There is no question that it is very rare that frivolous suits are brought against doctors. They are too expensive to bring.”<sup>18</sup>

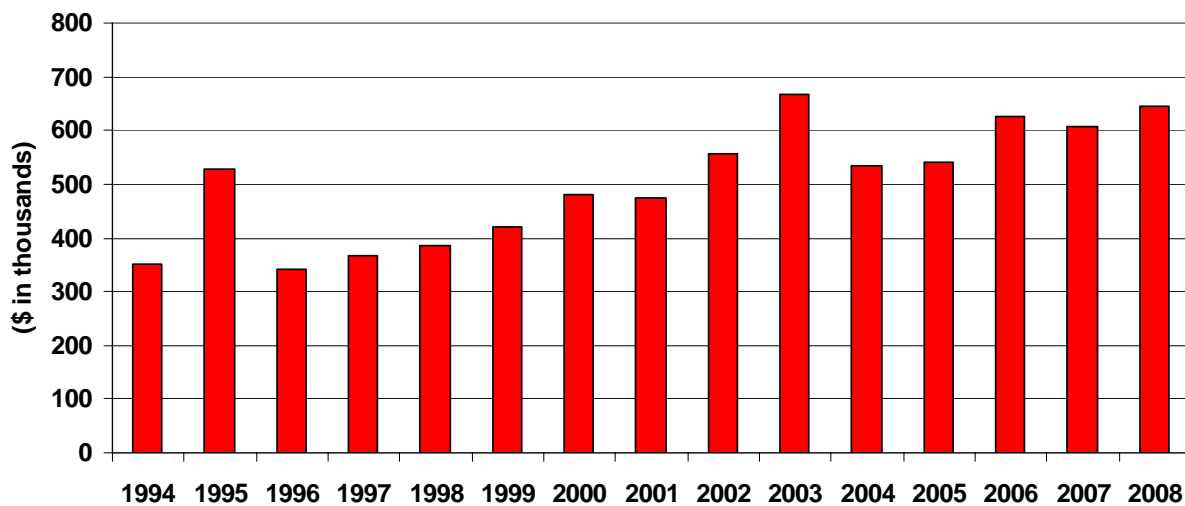
Still other deceptive reporting practices by ISMIE served to inflate claim figures. ISMIE provided selected closed claim records to the General Assembly in 2004 which included many “claims” which were open for only months, weeks, or days, for which nothing was spent on administrative or defense costs.<sup>19</sup> After the cap was enacted in 2005, ISMIE representatives belatedly admitted under oath that the broad definition that it had been using for “claim” also included “incidents,” which are not really claims at all, let alone lawsuits. “Incidents” included a request or subpoena for the doctor’s records, a subpoena to give a deposition, being named as a respondent in discovery, a complaint from the Department of Professional Regulation and even the belief of a doctor that he had committed an action for which he would be sued even when no lawsuit was ever filed.<sup>20</sup> After learning of this, the Director of the Illinois Department of Insurance ordered ISMIE to cease this practice of counting these other types of “incidents” as claims.<sup>21</sup>

In short, there was no real increase in frequency of claims, and ISMIE’s assertion otherwise was based on statistical trickery.

**B. “Severity” was Also Stable, or Even Decreasing**

“Severity” is “insurance-speak” for the amount of a claim payment. In 2005, ISMIE told the General Assembly that severity was dramatically rising, but this assertion is belied by ISMIE’s own filings with the Department of Insurance which show that its average claim payment had essentially peaked by 2003 and had plateaued thereafter.

**ISMIE - Average Paid Claim Amount by Year**



If the average payment per claim had merely *kept pace with medical inflation*, (9.3 percent in 2000, 11.3 percent in 2001, 10.7 percent in 2002, 8.4 percent in 2003, and 8.2 percent in 2004<sup>22</sup>) it would have risen from its level of \$480,000 in 2000 to over \$771,000 in 2004, the year before the enactment of the damages cap. Instead, the average payout in 2004 was only \$535,000 – far *below* the rate of medical inflation. The average amount ISMIE paid on a claim in 2004 *even without adjusting for inflation* was slightly less than the average of \$558,000 in 2002 and 20 percent less than the 2003 average of \$667,000.<sup>23</sup> In 2005, ISMIE inflated the average

numbers to generate phony hysteria and influence elected officials and the media to support the damages caps.<sup>24</sup>

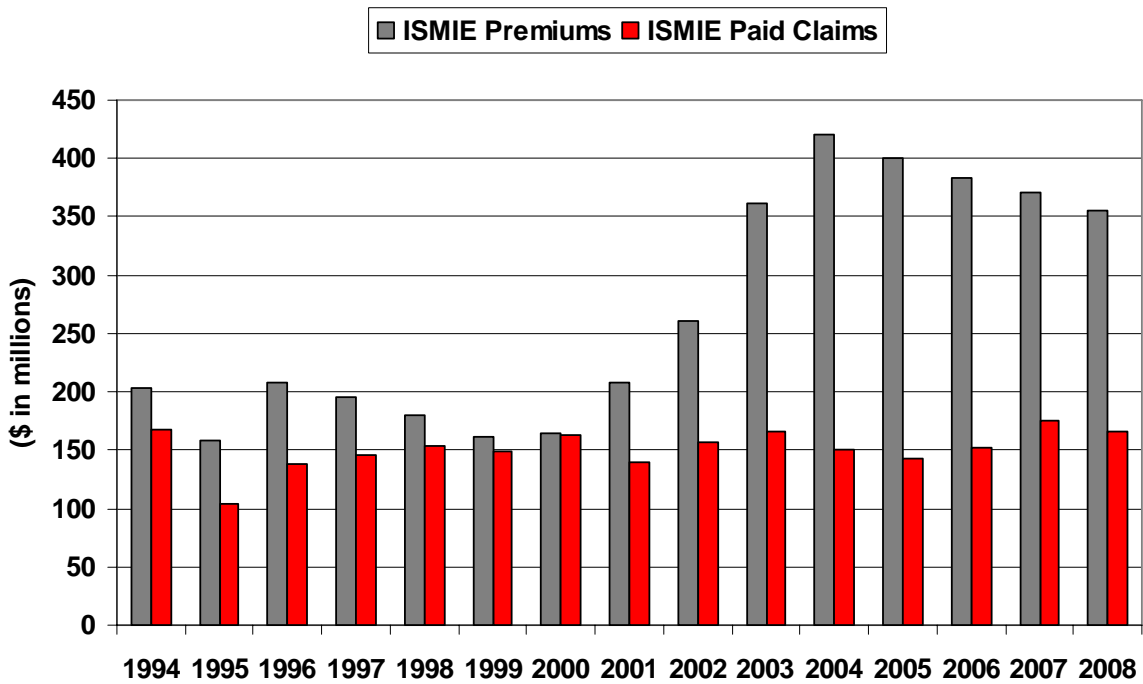
Moreover, ISMIE's cry of increased "severity" ignores how severity actually affects its payouts and rates. ISMIE purchases *reinsurance* to cover claims in excess of \$500,000, meaning that *all of its risk in excess of \$500,000 is transferred to the reinsurer, no matter how many ISMIE doctors or clinics are sued*. A mere 7.4 percent of the total insurance premiums paid by doctors funds this reinsurance cost – a low figure showing that the reinsurance market recognizes that the assertions of increased "severity" were phony from the start.<sup>25</sup> ISMIE has stated that it is comfortable with its level of reinsurance,<sup>26</sup> a level which ISMIE representatives have admitted under oath allowed it to absorb annual total estimated claim payout errors up to \$90 million per year.<sup>27</sup>

A further reality of "severity" is that it is rudimentary math that if an insurer is paying out a consistent total amount each year for all claims (as shown in Section C) with fewer claims paid each year, the average claim "severity" will rise. At a rate hearing in September 2005, after the enactment of the damages caps, the Director of the Department of Insurance pressed ISMIE executives for verification of ISMIE's claim of increased severity of claims.<sup>28</sup> ISMIE representatives admitted under oath that *they had no actual data to support the assertion of an increase in severity*.<sup>29</sup>

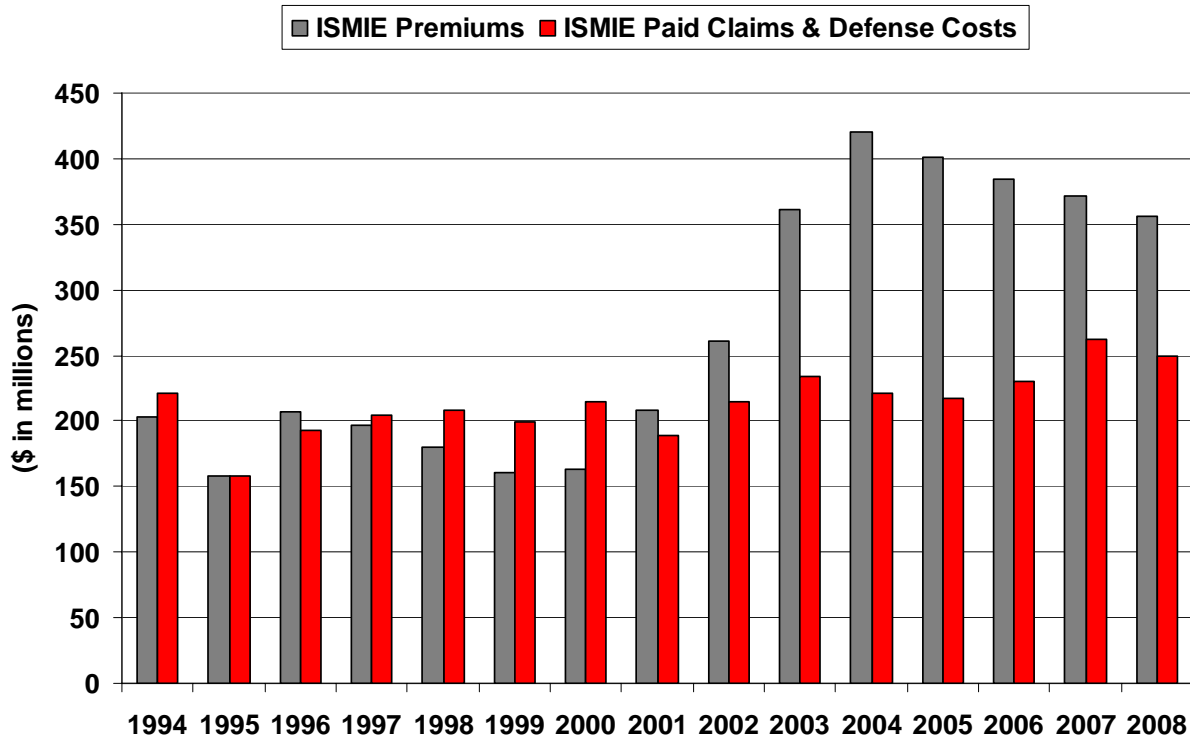
Thus, both premises of the damages cap – supposed increases in frequency and severity of claims – were completely false.

### C. Total Annual Payments Were Stable

ISMIE's total annual payments also refute arguments for its rate increases. ISMIE's annual statements filed with the Department of Insurance demonstrate that since 1994 its total annual payouts have been remarkably stable (between \$138 million to \$175 million except when payouts plummeted to \$100 million in 1995), while it has collected *twice as much or more in premiums each year*.



Adding defense costs to the claim payouts shows a similar pattern:



As will be discussed further in Section E, the combination of stable payouts and increased insurance rates facilitated record profits and well compensated executives.

#### D. “Judicial Hellholes” Are Another Myth.

The claim that there are three “judicial hellholes” in Illinois, specifically Cook, Madison and St. Clair counties, is a malignant myth. These counties have been unfairly and falsely tagged by corporations and insurance company special interests as legal venues attracting soaring numbers of lawsuits resulting in allegedly excessive jury awards.

There is no evidence in these supposed “hellholes” of a lawsuit epidemic, of increased jury trials, or of increased plaintiff success rates.”<sup>30</sup> An academic study concluded that “[e]xcept for a decrease in 2004, filings have remained relatively steady since 1998, although there are some yearly fluctuations.”<sup>31</sup> In particular, the study found that from 1996 to 2001 in Cook County, the number of jury trials held relatively steady. In 2002, the number of trials

increased only 10 percent. In 2003, the number of trials *decreased* to 99. In 2004, there were two more trials than 2001. In 2003, it was reported that the average jury award in medical malpractice cases tried in Cook County had dropped to a three-year low.<sup>32</sup> From 1999 to 2003, the number of Cook County claims paid by ISMIE steadily decreased from approximately 220 to about 160.<sup>33</sup>

Court records from St. Clair and Madison counties show:

- Out of nearly 400 malpractice and wrongful death cases filed in St. Clair County between 1996 and 2003, *only three* resulted in jury verdicts. Plaintiffs won two, both involving Memorial Hospital in Belleville (\$950,000 and \$780,000), and one was in favor of the defendants.<sup>34</sup>

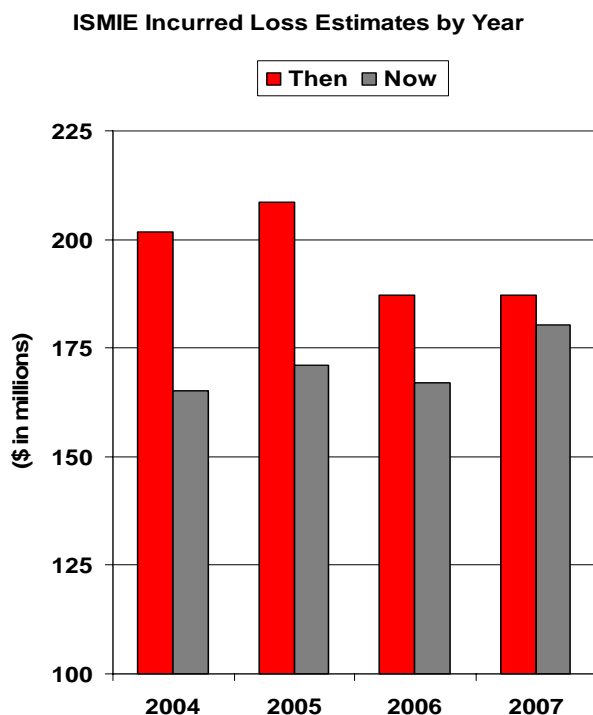
- Out of 320 medical malpractice and wrongful death cases filed in Madison County between 1996 and 2003, *only eleven* resulted in verdicts — four in favor of plaintiffs (\$1.8 million, \$470,000, \$75,000 and \$25,000) and seven in favor of defendants.<sup>35</sup>

ISMIE's 1999 to 2003 closed claim records for Madison and St. Clair counties show that, ISMIE paid no more than 10 claims per year in St. Clair County and no more than 11 in Madison County. The average paid claim was less than \$400,000 and *over 80 percent of those claims were settled for less than \$250,000.*<sup>36</sup> For each year, only \$5 million per year was paid out in both counties combined, a very small fraction of ISMIE's statewide payments (see Section C). ISMIE has not released numbers by county since 2003.<sup>37</sup>

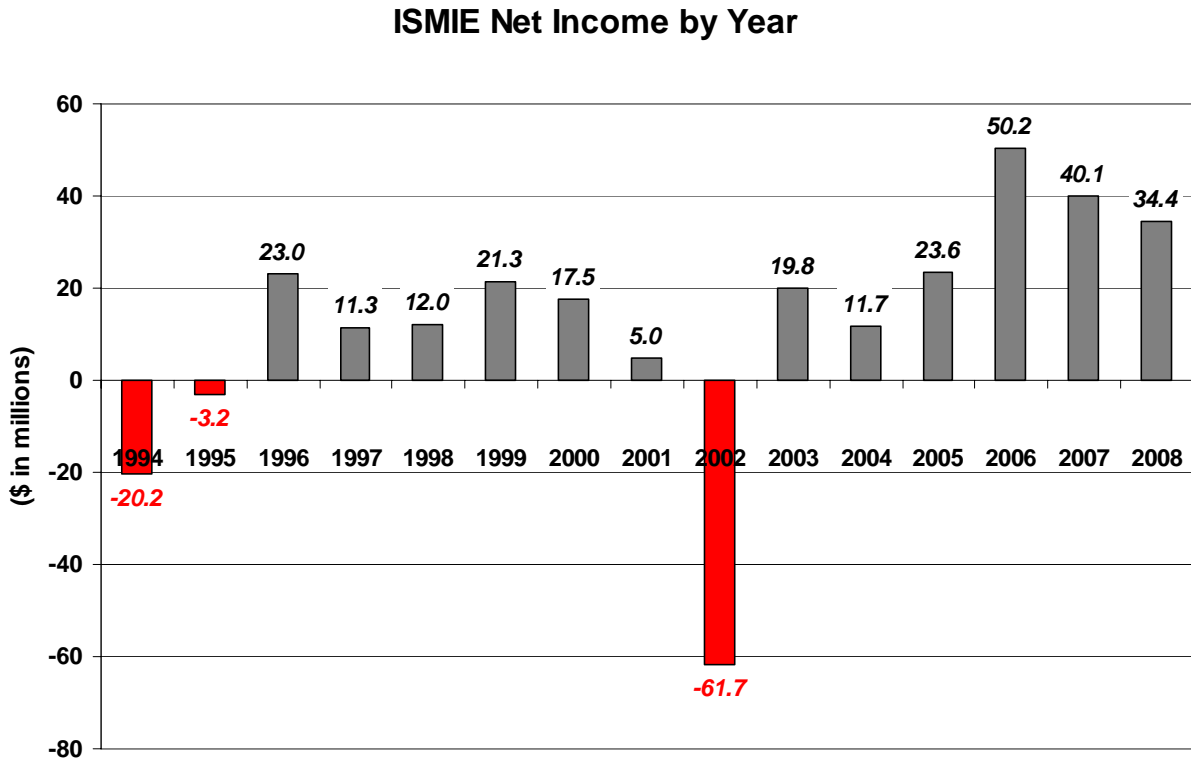
Hence, the “judicial hellhole” claim is another myth.

**E. Medical Malpractice Insurance Rate Increases Resulted in Record Profits and Gold-Plated Compensation for Executives.**

ISMIE’s own data from 2000-2004 (and thereafter) show an extended period of stability of claim frequency, claim severity and total payouts. “Reserves” are the amounts an insurer sets aside to pay claims. Not surprisingly, ISMIE’s rate increases served to generate large insurance reserves for the company. This was exacerbated by ISMIE’s practice of consistently *over-estimating its reserve requirements* (also known as “incurred losses”), calculating premiums on that basis, and then *revising its reserve requirements downward later*. For example, in 2003, ISMIE predicted that it would ultimately be required to pay out \$188.6 million for claims from that year but the next year had revised this estimate down to \$150.7 million, a decrease of over 20 percent. In 2004, ISMIE predicted that it would ultimately be required to pay out \$201.6 million for claims from that year, but has now revised this amount downwards to \$165.1 million, or a drop of 18.1 percent. Its 2005 estimates were overestimated by a similar percentage.



Not surprisingly, ISMIE’s business practices have generated record profits, also known as “net income,” which doubled in three consecutive years (2004 through 2006), with a record profit of \$50.2 million in 2006. ISMIE added profits of \$40 million in 2007 and \$34 million in 2008.



ISMIE’s net income loss of \$61.7 million in 2002 was followed by its 35 percent across-the-board rate increase in 2003, which it has attributed to increased frequency and severity of claims, however, ISMIE has admitted that, “...[I]nvestment income was down in 2002 because of the drop in interest rates. Additionally, ISMIE realized significant losses from the sale of WorldCom, Tyco, and Qwest securities.”<sup>38</sup> ISMIE’s own explanation shows the absence of any link to the supposed medical malpractice “crisis.”

ISMIE's net income of \$50.2 million in 2006 and \$40.1 million in 2007 represented the *most profitable years in its 32-year history*.<sup>39</sup> ISMIE's records show that even as it was asserting market conditions had forced it to raise insurance rates, it was spending large sums on *political campaigns, executive loans and big-ticket salaries*.<sup>40</sup> ISMIE, which insured 60 percent of Illinois physicians – had doled out to CEO Alexander Lerner and other ISMIE executives a variety of perks since the late 1990s. Meanwhile the insurer was raising premium costs by 120 percent in some cases.<sup>41</sup> “The fall in claims was good news for ISMIE's bottom line, which more than doubled, and for the pocketbooks of top executives, some of whom got raises as large as 33 percent. CEO Alexander Lerner – one of six ISMIE execs who pull down \$400,000 or more annually – saw his pay rise 4.5 percent to nearly \$1 million.”<sup>42</sup> In 2002, ISMIE paid \$4.9 million to Donald Udstuen, its former chief operating officer, just before he pleaded guilty to crimes of dishonesty.<sup>43</sup> The next year, ISMIE increased its premiums by 35 percent. Dr. Frank C. Madda, an ISMIE-insured doctor who unsuccessfully sought a seat on the ISMIE board of directors, noted that “[t]he whole thing stinks to high heaven.”<sup>44</sup>

In short, ISMIE's own data show that the dramatic increases in premiums between 2000 and 2004 were not needed to pay claims, because there was no increase in total payouts, claim frequency or severity. Instead, the premiums produced record insurance company profits and gold-plated compensation packages for insurance executives.

**F. Insurance Rates are a Function of Industry Practices and General Economic Factors.**

Experts studying medical malpractice insurance companies have concluded that “[w]hile insurers and other tort reform proponents blame malpractice litigation for the hard market premium increases, they are in fact consistently driven by the insurance companies'

response to the broader economic cycle.”<sup>45</sup> State insurance regulators, including the former Acting Director of the Illinois Division of Insurance, agree.<sup>46</sup>

ISMIE told the General Assembly that some doctors’ malpractice insurance companies left Illinois in the years leading up to 2005 because of the litigation environment in the State. However, in filings with the Security and Exchange Commission (SEC) in 2000,<sup>47</sup> ISMIE said there were six malpractice companies in 1992, and that later in the 1990s, a competitive market developed when the stock market was booming and medical malpractice insurance was more profitable and an additional twenty or so companies entered the Illinois market. ISMIE told the SEC that the additional companies left *as soon as the stock market went down* and the insurance “hard market” hit around 2002, so as of 2005, there were five companies. This was *a net loss of only one since 1992*. The number of companies was a function of trends in the financial markets, not of claims (which were stable in any event). Furthermore, in the 2005 insurance rate hearings looking into ISMIE’s rate increases, ISMIE representatives admitted under oath that the company’s 2000-2004 rate increases were an attempt to catch up after insurance market conditions had reduced its profitability.<sup>48</sup> In fact, its representatives acknowledged under oath that ISMIE discovered in 2002 that it had mismanaged its reserves and failed to maintain them at adequate levels.<sup>49</sup> Its rate increases had been an attempt to compensate for its own business mistakes.

Another major factor behind the rate increases was that ISMIE was “not getting the investment yield that it might have received at one time . . . .”<sup>50</sup> Almost all of ISMIE’s investments are in fixed-interest assets.<sup>51</sup> The interest rate on those assets dropped from about 6 percent during a “soft” market to about 3 percent by 2005.<sup>52</sup> *Each 1 percent drop in the interest led to ISMIE’s raising its premium rates by 5 percent to 6 percent.*<sup>53</sup> Thus, ISMIE representatives admitted under oath that a very substantial portion of its rate increases was

required by changes in its investment outlook, even setting aside ISMIE's past mistakes in pricing in the earlier "soft" market. In short, ISMIE's claims payments had nothing to do with its rate increases.

Independent scholarship has overwhelmingly concluded that malpractice insurance rates are a function of business conditions and investment income rather than claims. Thomas Baker, a professor at the University of Pennsylvania Law School and formerly the director of the Insurance Law Center at the University of Connecticut, has carefully reviewed the available empirical evidence:

[T]he two most recent medical liability insurance crises [mid-1980s and early 2000s] did not result from sudden or dramatic increases in medical malpractice settlements or jury verdicts. Instead . . . the crises resulted from dramatic increases in the amount of money that the insurance industry put in reserve for claims. Those reserve increases were so big because the insurance industry systematically under-reserved in the years leading up to the crisis.<sup>54</sup>

Another group of scholars (one of whom testified on the same subject at Illinois House Judiciary Hearings in 2005) analyzed fifteen years of closed medical malpractice claims in Texas and reached the same conclusion:

This evidence suggests that no crisis involving malpractice claim outcomes occurred. It thus also suggests a weak connection between claims-related costs and short-to-medium-term fluctuations in insurance premiums. . . . [T]he more likely explanation is that much of the rise in premiums reflects insurance market dynamics, not litigation dynamics.<sup>55</sup>

The Wall Street meltdown of 2008-2009 provides another illustration of the cyclical nature of financial markets. The fact that insurance companies' revenues are closely tied to the performance of their investments underscores the irrelevance of claims and lawsuits, let alone caps on them, in determining insurance rates.

**G. Insurance Reform has the Only Real Effect on Malpractice Insurance Rates - Not Caps on Damages.**

To be sure, overall since 2005 medical malpractice insurance rates for individual doctors have not increased as sharply as they did in the period from 2000-2004. However, in 2005 ISMIE increased rates for a large number of specialties, including cardiologists, family practice doctors, general practitioners, infectious disease specialists, and nephrologists, and *increased* rates for *all* corporations/clinics by 25 percent.<sup>56</sup> ISMIE has stated that it kept its rates “steady” for 2007 and 2008 – but “steady” is not what it promised when seeking the damages cap in 2005. As one doctor commented, “They’re making a lot more money now, and we still haven’t seen our rates go down.”<sup>57</sup>

To the extent insurance rates went down, any decrease cannot be attributed to the damages cap. “ISMIE has said publicly that the caps won’t justify rate cuts until a court upholds the limits against expected court challenges.”<sup>58</sup> In addition, proponents of the caps testified before the General Assembly that, even after the cap was implemented, there would be a three-year lag before it would have a financial impact.<sup>59</sup>

ISMIE has a reputation for stifling competition. “ISMIE complained to Aon (a reinsurer) in the mid-1990s that Aon’s brokers were taking their clients away from ISMIE and directing them to buy insurance from competing firms. According to two former Aon employees with direct knowledge of the situation, ISMIE’s chief operating officer (Donald Udstuen) met with representatives of Aon’s reinsurance brokerage and threatened to fire Aon as its reinsurance broker unless Aon brokers stopped taking their clients to ISMIE’s competitors. After the meeting, Aon’s insurance brokers were told to stop redirecting their clients away from ISMIE, the sources said.”<sup>60</sup>

A competing insurance executive explained “ISMIE’s near-monopoly has really squeezed anybody from coming in here. Nobody knew how to set their rates.”<sup>61</sup> Under insurance reforms enacted along with the damages cap in 2005, ISMIE was required for the first time to make its actuarial and claims data available to its previously disadvantaged competitors. This new access has allowed competing insurance companies to accurately assess how to write policies in Illinois and to set competitive rates. The positive effect of the insurance market reforms has been noted by no less an authority than Michael McRaith, Director of the Illinois Department of Insurance, who explained: “For the first time in the history of the state, [malpractice] insurance companies that want to compete for business in Illinois have access to actuarial information and loss and claims data...*We see more companies coming in and a stabilization or decline in actual rates.*”<sup>62</sup> Director McRaith added “[m]ore companies are looking at Illinois as a viable marketplace because of the availability of this data”<sup>63</sup> – not that the caps were effective. ISMIE competitors agree. “Ann Storborg, Vice President of Investor Services for Michigan-based American Physicians Capital Inc., says it helped to have access to ISMIE’s data as a benchmark.”<sup>64</sup>

Thus, insurance reform – not caps on damages – is the proper remedy. The American Bar Association, for example, has consistently advocated that the insurance industry should be subject to the same antitrust laws as every other industry and that Congress should amend the McCarran-Ferguson Act to eliminate the insurance exception to the antitrust statute.<sup>65</sup>

Caps on damages in malpractice cases have been low in California since 1976. Thirteen years after the enactment of those caps, doctors’ malpractice insurance rates had increased by 450 percent and reached an all-time high.<sup>66</sup> In 1988, Proposition 103 was passed by California voters which:

- Rolled back rates to 20 percent lower than rates in effect the year before for all property and casualty insurers, *including medical malpractice insurers*
- Froze rates for one year.
- Refunded billions of dollars to policyholders.
- Created “prior approval” regulation of insurers, which allows the insurance commissioner to reject or alter rate increase requests.
- Allowed consumers to challenge insurers’ rate increase proposals.
- Ended the insurance industry’s exemption from anti-trust laws.
- Made the Insurance Commissioner an elected position.

Proposition 103 mandated refunds to be paid by major medical malpractice insurers. In the early 1990s, three of the state’s largest malpractice insurers – The Doctors Co., Norcal Mutual and SCPIE – refunded \$69 million to doctors to comply with Proposition 103.<sup>67</sup>

In fact, nationwide data show that average malpractice insurance rates for physicians as a whole are nearly identical in states with and without damages caps.<sup>68</sup> Average insurance rates for obstetrician/gynecologists (“OB/GYNs”) are similarly virtually identical in cap and non-cap states.<sup>69</sup> Average insurance rates for general surgeons are 9.3 percent higher in states with caps.<sup>70</sup> Average insurance rates for internal medicine are 9.9 percent higher in states with caps.<sup>71</sup>

A study by a third-party ratings agency found that in states with damages caps, the median annual malpractice insurance rates increased by 48.2 percent between 1991 and 2002, but in states without caps, the median annual rates rose at a *slower* rate—by 35.9 percent. Among the states with caps, only 10.5 percent experienced flat or declining medical malpractice insurance rates. In contrast, among the states without caps, the record was actually better: 18.7 percent experienced flat or declining rates. The study concluded that

“[t]here are other, far more important factors driving the rise in med mal premiums than caps or med mal payouts.”<sup>72</sup>

The experience of states surrounding Illinois is instructive as well. Iowa, which has lower indemnity payouts than Illinois, has not enacted a cap on noneconomic damages but instead has adopted a more aggressive program of professional discipline for negligent doctors.<sup>73</sup> Indiana, which in 1975 enacted one of the nations strictest caps on total medical malpractice damages, experienced an *increase* in claims and payments during the 1980s.<sup>74</sup>

A high-level insurance executive has been candid in saying, “I don’t like to hear insurance-company executives say it’s the tort system – it’s self-inflicted.”<sup>75</sup> An internal document citing a study written by Florida insurers regarding that state’s omnibus tort “reform” law of 1986 said that “[t]he conclusion of the study is that the noneconomic cap . . . [and other tort ‘reforms’] will produce little or no savings to the tort system as it pertains to medical malpractice.”<sup>76</sup> Sherman Joyce, President of the American Tort Reform Association (ATRA—the very organization that has rated certain Illinois counties as “judicial hellholes”) has admitted: “We wouldn’t tell you or anyone that the reason to pass tort reform would be to reduce insurance rates.”<sup>77</sup> Victor Schwartz, General Counsel of the ATRA, has admitted: “Many tort reform advocates do not contend that restricting litigation will lower insurance rates, and I never said that in 30 years.”<sup>78</sup> Ed Murnane, Chairman of ATRA and the longtime President of the Illinois Civil Justice League, the main Illinois front group for insurance companies supporting caps, admitted in 2005 that caps will not lower insurance rates for doctors: “*We have never made the claim that a cap is going to lower insurance rates.*”<sup>79</sup>

Thus, the reduction in insurance rates since 2005 is plainly *not* due to the damage caps but to other provisions of Public Act 94-677—specifically, insurance rate regulation, rules for creating transparency and competition in the insurance market, and other insurance

regulatory measures. On March 14, 2006, under this new authority and as follow-up to the ISMIE rate hearings which had taken place in late 2005, the Department of Insurance ordered ISMIE to reduce its insurance rates, create a dividend distribution process to give refunds to policyholders, and change the manner in which it was counting claims.<sup>80</sup> These reforms, and not the damages cap, directly addressed the issues of abuses in the insurance industry, which have been a major factor leading to higher insurance rates.

A cap is not the answer to any problems with medical malpractice insurance rates- insurance reform is.

## **II. Medical Malpractice Claims Have Had Little Effect on Hospitals' Bottom Line.**

Hospitals have also asserted that they are threatened by rising malpractice claims. Although hospital representatives testified before the General Assembly in 2005 as to the number of claims they faced, the internal data they presented has never been placed in the public domain and therefore has not been independently verified.<sup>81</sup> There is ample reason to be skeptical of the hospitals' assertions. For example, after the hospitals submitted to the General Assembly their selective analysis of Cook County verdicts, re-analysis (which included complete verdict data) showed that noneconomic damages awards against hospitals actually *declined* from 2002-2003.<sup>82</sup>

Moreover, hospitals have been prospering financially, even before any impact could have been realized from the damages caps. Northwestern Memorial Hospital reported a net profit of \$142.9 million for 2007, an increase of 33.3 percent from 2006.<sup>83</sup> The University of Chicago Medical Center reported a net profit of \$140.8 million for 2007, Rush University Medical Center reported \$120.7 million, and Loyola University Medical Center reported \$31.1

million.<sup>84</sup> The University of Chicago Medical Center's net profit was up 32 percent in 2008 to almost \$190 million.<sup>85</sup>

Advocate Health Care Network has reduced its self-insured retention for general liability and professional liability claims from \$15 million to \$12.5 million,<sup>86</sup> not through a damages cap but by instituting safety measures including onsite obstetricians and mandatory breaks for surgeons.<sup>87</sup>

Advertising for Chicago metropolitan hospitals is ubiquitous. The hospitals are also the subject of news stories -- and not because of a medical malpractice crisis:

- Northwestern Memorial Hospital's 2004 investment income increased to \$68 million, up from \$7.9 million in 2003.
- Northwestern Memorial Hospital's 2004 net profit was up 448 percent from 2003.
- Northwestern Memorial Hospital is reported to have \$1 billion in assets.
- Northwestern Memorial Healthcare's retiring CEO received a \$17 million golden parachute when he retired in 2006.<sup>88</sup>
- Northwestern is moving to purchase the site of Lakeside VA Hospital, after already spending over \$1 billion on additions to its campus over the past decade.<sup>89</sup>
- Northwestern recently opened a luxurious \$507 million women's hospital featuring "spectacular lake views and 42-inch flat-screen televisions loaded with movies for order."<sup>90</sup>
- Northwestern is planning to replace or rebuild Lake Forest Hospital at the cost of hundreds of millions of dollars.<sup>91</sup>
- Advocate Health Care's 2004 investment income increased 73 percent, to \$69 million from \$40 million in 2003.
- Advocate Health Care's 2004 net profit was \$148 million, up 16 percent from 2003.
- Advocate Hospitals continues to acquire new hospitals and expand upon existing ones.<sup>92</sup>

- The Rehabilitation Institute of Chicago recently announced it has purchased the property upon which it will be building a new hospital costing several hundred million dollars.<sup>93</sup>
- The State Health Planning Board rejected requests for two new hospitals in Lake County because the county already has too many hospital beds.<sup>94</sup>

In 2005, representatives from the Chicago Hospital Risk Pooling Program (CHRPP), affiliated with the Metropolitan Chicago Healthcare Council, told the General Assembly that independent factors in the insurance market had nothing to do with the hospitals' problems. However, earlier that year the same Council had said precisely the opposite, as the following quotes from its slides show:

#### **A. The Medical Liability Crisis: Why Does it Exist?**

During the 1990s, medical liability was *one of the most profitable lines of insurance* in the casualty industry.

- Lower than expected claims losses.
- A reduction in funds set aside to cover future liability.
- Low overall inflation, and equally-low health inflation.
- Solid returns on insurance company stock market investments.

Malpractice insurers responded by only modestly increasing premiums. Many even scaled back their rates.

#### **B. The Medical Liability Crisis: Why Does it Persist?**

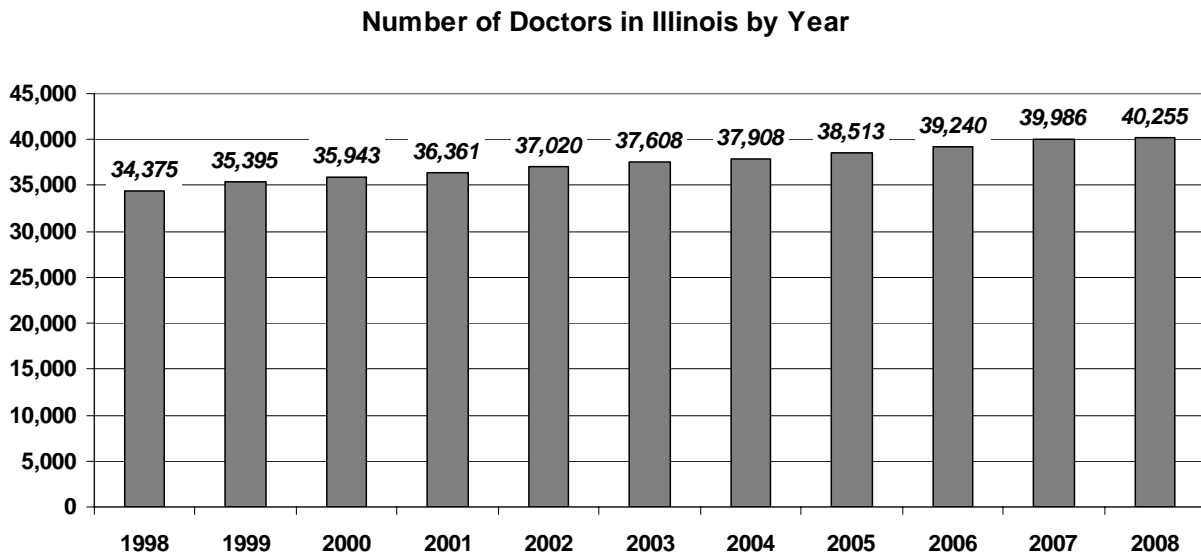
Today, however, few insurers remain in the metro Chicago area. The reasons:

- Insurers' investment income has declined
- To boost insurance company profitability in what has been a down or stagnant economy, the insurers that remain continue to raise their premiums to boost revenues and improve their balance sheets."

Thus, the hospitals' own statements show that insurance and investment markets – and not tort claims – are the reason for any financial difficulties they may have faced in the past.

### III. The Physician “Exodus” is a Myth and Cannot Justify Caps.

Rising malpractice insurance rates have supposedly caused a physician “exodus” from Illinois. This allegation is false. Quite simply, Illinois has been gaining doctors, not losing them. Since 1963 (the earliest year for which comprehensive data was publicly available from the American Medical Association (“AMA”)), and particularly from 1998 to 2008, the number of total patient care doctors in Illinois steadily *increased*:



Source: Physician Characteristics and Distribution in the U.S., Various Editions,  
American Medical Association

According to official statistics compiled by the AMA and the Illinois Department of Public Health, the number of physicians licensed and engaged in “patient care” in Illinois has steadily increased and has *never declined* for the past 45 years, both in net numbers and in relation to Illinois’ rising population.<sup>95</sup> Significantly, this consistent trend spans both (i) the “crisis” periods that preceded enactment of other tort reform measures struck down in 1976, 1986, and 1997, and (ii) the periods after those decisions were decided, during which cap proponents had predicted that doctors would flee unless the caps were upheld.

In fact, Illinois has consistently had a higher rate of “physicians per 100,000 residents” – the metric of physician availability used by the AMA to compare one state to another and one period to another – than twelve of Illinois’ thirteen neighboring states, nine of which have caps on medical malpractice damages.<sup>96</sup> The rate of licensed physicians has risen from 134 doctors per 100,000 persons in 1963 to 302 doctors per 100,000 persons in 2005.<sup>97</sup> The only state with a higher rate of doctors per capita is Minnesota, *which has never had a cap*.

In 2005, only fifteen states in the country had a higher rate of licensed physicians per 100,000 population than Illinois – Connecticut, Hawaii, Maine, Maryland, Massachusetts, Minnesota, New Hampshire, New Jersey, New York, Oregon, Pennsylvania, Rhode Island, Vermont, Virginia, and Washington.<sup>98</sup> Only *three* of those fifteen states have damages caps: Maryland, Massachusetts, and Virginia. Illinois also has more doctors per capita than three other states – California, Ohio, and Texas – frequently cited by tort reformers because of their damages caps.<sup>99</sup>

Nor are caps effective, let alone necessary, to remedy any supposed problem of physician “flight” in medical sub-specialties. Data from the AMA and the Illinois Department of Health show continuing increases over the past 45 years in both the number and the per capita rate of Illinois licensed and patient care physicians practicing in medical specialties such as OB/GYNs and neurosurgeons.<sup>100</sup> Illinois’ leading business journal observed in 2005 that “data likewise fail to support the medical lobby’s claims that Illinois is losing doctors in those specialties. An analysis by the American Board of Medical Specialties shows Illinois registered 3 percent or more neurosurgeons and 2 percent more OB/GYNs in the past year.”<sup>101</sup>

Further, the number of physicians practicing in the 51 counties in the largely rural half of the state south of Springfield has even steadily increased, both in total numbers and in

proportion to the region's population.<sup>102</sup> The rate of all licensed doctors in southern Illinois rose from 141.71 per 100,000 population in 1995, to 163.73 per 100,000 population in 1999, and to 179.91 per 100,000 population in 2005. Similarly, the rate of all primary care physicians rose from 118.99 per 100,000 population in 1995, to 134.20 per 100,000 population in 1999, and to 147.99 per 100,000 population in 2005.

The claim of "doctor flight" has always been suspect. A 2005 report noted that "[t]he number of doctors licensed in Illinois rose 9 percent in the last three years, despite assertions that physicians are fleeing to neighboring states with lower malpractice insurance rates."<sup>103</sup> A spokeswoman for the Illinois Department of Financial and Professional Regulation explained, "We're not seeing an unstable market for docs in Illinois."<sup>104</sup> By comparison, during the same time period (2002 through 2005), the number of licensed doctors in Indiana, which has had a damages cap in medical malpractice cases since the 1970s, declined by 18 percent.<sup>105</sup> "[L]icensing data for Illinois and the surrounding states doesn't reveal any correlation between the physician population and liability caps."<sup>106</sup>

In 2003, the Center for Organization and Delivery Studies at the U.S. Department of Health and Human Services compared physician supply in 1970 and 2000 in each state and found that the per capita supply of doctors in Illinois increased by 74.2 percent, more than that experienced by many states that capped medical malpractice damages.<sup>107</sup> At the same time, eleven of the eighteen states that experienced the highest (more than 100 percent) growth in per capita supply of doctors did not have caps.

One reason that caps have not produced a growth in physician population is that malpractice insurance does not represent a significant portion of a doctor's expenses. Suffolk Law Professor Marc Rodwin and several colleagues published a study based on thirty years of AMA data in *Health Affairs* (the leading peer-reviewed journal of health policy and

research). The study concluded that, while the “list price” of malpractice premiums periodically rose and fell from 1970 to 2000, the premiums actually paid by physicians rarely exceeded 10 percent of a doctor’s “total practice expenses” – typically amounting to only 6 to 7 percent of those expenses – and an even smaller percentage of a doctor’s “total practice income” or gross revenue.<sup>108</sup> Office rent, medical supplies and equipment, and health insurance for staff all absorb a far greater portion of a physician’s expenses. Moreover, the study found that a far greater cause of physician dissatisfaction was declining practice revenue stemming from the policies of Medicaid, Medicare, and HMOs/PPOs to limit reimbursements for medical procedures.

California, which has had damages caps for over 25 years, confirms that caps do not address doctors’ real complaints. The California Medical Association conducted a survey of 19,000 physicians and found that 58 percent reported having experienced difficulty attracting other physicians to join a practice. More than 25 percent of physicians had difficulty in recruiting doctors in various counties in California, particularly in primary care, neurology, orthopedic surgery, and neurosurgery. More than one-fourth of physicians stated that they would no longer choose medicine as a career if starting over today, and more than one-third of those who would still choose medicine would not choose to practice in California. Forty-three percent of all California doctors planned to close their practices within three years. The study included letters from specialists, including OB/GYNs and neurosurgeons, predicting that in the near future there would be no specialists in many areas of California. The primary reasons cited for leaving were low insurance reimbursement, problems with managed care plans, and government regulation.<sup>109</sup> Hence, a cap does not address any of the reasons for doctor dissatisfaction or flight.

An exhaustive nationwide study showed that the supply of OB/GYNs had no statistically significant association with malpractice insurance rates or tort reforms and that damages caps do not help states attract and retain high-risk specialists.<sup>110</sup>

Another recent study found that New York data “also contradict another claim often made by hospital lobbyists and doctors’ advocates: that high malpractice premiums are driving doctors out of the state. In fact, the report states the number of doctors practicing in New York has grown at a rate more than five times the rate of growth in the state’s population.”<sup>111</sup>

Moreover, the physician “flight” argument fails to acknowledge that some doctors – those guilty of repeated acts of malpractice – *should* be leaving the profession. The National Practitioners Databank reports that 5 percent of the doctors who have made malpractice payments over the last fifteen years were responsible for almost one-third of the costs.<sup>112</sup>

In 2005, the St. Clair County Medical Society and local hospitals ran ads claiming that 160 various unnamed specialists had supposedly left the area because their malpractice rates were so high. *Despite repeated requests for the names of these specialists, none have ever been disclosed.* William Sprich, formerly of St. Clair County and now practicing in Missouri, is a neurosurgeon who can safely be assumed to be on that “list.” Seven lawsuits were filed against him in the 1990s and thirteen from 2001 through 2004. One of the cases was filed by a patient, himself a doctor, who sustained severe injury from spine surgery, during which Dr. Sprich allegedly ignored the warnings of the operating room nurses that the equipment he was using was defective. The Illinois Department of Professional Regulation responded to this incident with only a reprimand. But when this same incident was reported to the authorities in Ohio in 2003, his license was permanently revoked and then surrendered.<sup>113</sup>

John Petrovich, a Granite City surgeon, has been sued in at least fifteen cases. One suit alleged that a health care worker was fired by Granite City Hospital after stating that Petrovich was using cocaine. Petrovich also pled guilty in 2005 in the U.S. District Court for the Southern District of Illinois to one felony charge of health care fraud. Pursuant to the plea agreement, he admitted that he knowingly participated in a scheme to defraud the Illinois Medicaid program and his scheme was in connection with the delivery of prescription drugs. According to a statement issued by the U.S. Attorney, Petrovich admitted he rented a hotel room in Caseyville in 2004, where he was visited by a female Medicaid recipient. According to the U.S. Attorney, Petrovich admitted the purpose of the visit was not to provide medical treatment, but to prescribe anti-anxiety and pain relief medication for the Medicaid patient and others solely for recreational use. “Petrovich knew and understood that the Illinois Medicaid program would not pay for prescription drugs under those circumstances, and at times even told the beneficiary to pay cash rather than using Medicaid,” according to the statement.<sup>14</sup>

Proof of a doctor “exodus” is clearly lacking but even if there was such proof, it could not justify damage caps given (i) the absence of any link between malpractice litigation and malpractice insurance rates, and (ii) the failure of caps to lower malpractice insurance rates.

Tellingly, the widespread allegations and anecdotes about doctors fleeing Illinois abruptly *stopped as soon as the cap went into effect in 2005* – rather odd if they were leaving because of high malpractice insurance rates since there had *been no immediate drop in the very malpractice insurance rates that were supposedly making them leave*. The “physician exodus” claim is phony.

#### IV. Medical Malpractice Claims Have Little to no Effect on the Cost of Health Care

Proponents of caps have suggested that malpractice claims – in addition to raising malpractice insurance rates – also increase the cost of health care, both directly through jury awards and indirectly through “defensive medicine” and unnecessary procedures. Just as there is no evidence to support the malpractice insurance argument, there is no evidence to support the health care costs argument – an argument which has been refuted by objective scholarship time and again.

In 2004, the Congressional Budget Office (CBO) concluded that “even large savings in [medical malpractice] premiums can have only a small direct impact on health care spending – private or governmental – because malpractice costs account for less than 2 percent of that spending.”<sup>115</sup> In 2008, CBO again concluded that, “[b]y reducing the average size of malpractice awards, tort limits would ultimately reduce the cost of malpractice insurance premiums, but in CBO’s estimation, the effect would be relatively small – less than 0.5 percent of total health care spending.”<sup>116</sup>

On the issue of “defensive medicine,” CBO’s 2004 report found such evidence to be “weak or inconclusive”<sup>117</sup> and “at best ambiguous.”<sup>118</sup> The report also observed that malpractice premium increases were attributable at least in part to “reduced income from [insurance company] investments and short-term factors in the insurance market.” “Insurance companies’ investment yields have been lower for the past few years, putting pressure on premiums to make up the difference.”<sup>119</sup> In that same report, CBO concluded that, “[o]n the basis of existing studies and its own research, CBO believes that savings from reducing defensive medicine would be very small.”<sup>120</sup>

In 2006, CBO conducted its own empirical analysis of the link between tort reforms and the use of health care services and concluded that the results were “mixed” and

“inconsistent,” noting that some tort limits reduce spending, whereas others have no effect or actually increase spending.<sup>121</sup> In December 2008, CBO stated that “[t]he evidence . . . is not conclusive, and whether limits on malpractice torts have an impact on the practice of medicine has been subject to some debate.”<sup>122</sup> The report concluded: “The Congressional Budget Office has examined the issue by looking at the experience of states that implemented limits on torts and has not found sufficient evidence to conclude that practicing defensive medicine has a significant effect on health care spending.”<sup>123</sup>

Lakdawalla and Seabury (2009) concluded “policies that reduce expected malpractice costs are unlikely to have a major impact on health care spending for the average patient, and are also unlikely to be cost-effective over conventionally accepted ranges for the value of a statistical life.” Indeed, the researchers found that, based on the value of a statistical life, “malpractice reform is more likely to be cost-ineffective,” that “reducing malpractice costs is more likely to harm than improve social welfare,” and “any policymaker wishing to defend tort reform would need to depart from these accepted U.S. regulatory practices, and advocate a lower value of statistical life than conventionally used, in order to justify their case.”<sup>124</sup>

Avraham, Dafny, and Schanzenbach (2009) found the impact of tort suits on health care costs cannot be assessed. “To understand the social welfare implications of these reforms, however, additional research on health outcomes and long-run costs is needed.”<sup>125</sup>

Sloan and Shadle (2009) found “assertions that tort reforms will reduce waste of scarce resources seems, at best, highly premature,” and “it seems inappropriate to conclude that tort reforms implemented to date succeed in reducing non-beneficial care as their proponents would have it.”<sup>126</sup>

Baicker, Fisher, and Chandra (2007) concluded that malpractice premiums were not responsible for physician exodus or defensive medicine and that changes in health care

spending could not be deemed to be “defensive medicine”: “To the extent that additional malpractice costs mean greater precautionary testing with some medical value, any additional procedures might be protective of patient health or valued regardless of their therapeutic properties.” The study also found that “past and present malpractice payments do not seem to be the driving force behind increases in premiums.” The study cited other factors for premium increases, “such as industry competition and the insurance underwriting cycle.”<sup>127</sup>

Currie and MacLeod (2008) found that, in the context of childbirth, caps on damages “are found to increase procedure use, and hence costs. They also increase complications of labor and delivery in some specifications. Hence, in one important example, tort reform that reduces the malpractice risk facing doctors appears to increase rather than decrease procedure use, with potentially harmful effects on patients.” The study concluded: “Without knowing more about the specific incentives faced by physicians, it is hazardous to predict that a specific tort reform will either reduce unnecessary procedure use or have beneficial impacts on health.”<sup>128</sup>

Quite simply, quoting the headline of one recent editorial, “*Malpractice Suits Aren’t Driving the High Cost of Health Care.*”<sup>129</sup>

#### **V. Medical Malpractice is One of the Leading Causes of Death and Injury –Improved Patient Safety Prevents Malpractice Claims.**

Proponents of caps always ignore one inconvenient truth: medical malpractice, which is the root of medical malpractice claims and lawsuits, is one of the leading causes of death and injury in this country. The most direct way of reducing medical malpractice claims and lawsuits is to reduce the incidence of malpractice.

The Congressional Budget Office (CBO) has recently estimated that over 180,000 patients are injured every year by medical negligence.<sup>130</sup>

Tommy G. Thompson, Secretary, U.S. Department of Health and Human Services under the Administration of former President George W. Bush, has described the enormous social problem posed by medical malpractice:

“The Institute of Medicine’s (IOM) landmark 1999 report, *To Err is Human*, alerted the nation to the patient safety challenge in ways that prior studies had not. The IOM estimated that between 44,000 and 98,000 Americans die each year as a result of medical errors, making them the eighth leading cause of death in the United States. More people die from medical errors than from automobile accidents, breast cancer, or AIDS. While there has been subsequent debate about the actual number of deaths, it is clear that the rate of medical errors is unacceptably high.”<sup>131</sup>

Similarly, Newt Gingrich has criticized the medical profession:

“Consider this: Healthcare is the only industry in America that can give you a disease and then charge you to cure the disease it gave you. Clearly this is an outrageously wrong principle . . . . The enormous number of needless deaths from medical errors (44,000), hospital-induced infections (88,000), and medication errors (7,000) is not only unacceptable, it is un-American.”<sup>132</sup>

A truly national response to the IOM’s call to reduce preventable injuries by 90 percent requires that every health care board, executive, physician, and nurse make patient safety an absolutely top strategic priority—fully equal to the corporate priority of financial health. And *JAMA* said that at a national level, such a commitment has yet to emerge; indeed, it is not in sight<sup>133</sup>

Caps have the unjust effect of insulating negligent (and even grossly negligent) medical care providers from full accountability and instead forcing grievously injured patients to bear the costs of “reform.” Indeed, the cruel irony of a cap is that it comes into play only in meritorious cases, when a jury, trial judge, and reviewing courts all agree that a

plaintiff's claim has merit and that he or she is entitled to substantial damages. By definition, a cap has the greatest impact on the most deserving and most seriously injured.

The oversight, risk management, serious financial penalties for negligent and substandard care and other aspects of medical malpractice liability improve safety in the provision of medical care, contributing to consumer protection in the market for physician services.<sup>134</sup> Putting caps on damages would inhibit these efforts and hurt consumers.<sup>135</sup>

## **VI. History Repeats Itself- Medical Malpractice “Crises” are a Ten-Year Cyclical Occurrence**

The year 2005 was not the first time a claim had been made that there was a “medical malpractice” or “lawsuit” crisis. The General Assembly had heard this in 1975, 1985, and 1995 – a ten-year, repeating pattern that further underscores that insurance rates are related more to the business cycle and insurance company investment income than to lawsuits or claims. In response to each “crisis,” Illinois enacted laws that drastically limited the rights of injured victims, and despite the argument that the laws were necessary to address a supposedly pressing problem, court decisions struck down each of the laws as unconstitutional.

In *Wright v. Central DuPage Hospital Assn.* (1976), the court struck down a \$500,000 damages cap in medical malpractice cases. In *Bernier v. Burriss* (1986), the court struck down a system of medical review panels. And in *Best v. Taylor Machine Works* (1997), the court declared unconstitutional a \$500,000 cap on compensatory damages for noneconomic injuries in personal injury cases, including medical malpractice cases.

After each of these decisions, there were dire predictions of catastrophe: malpractice insurance rates would skyrocket, doctors would leave Illinois, and hospitals would shut down. None of this ever came to pass. In fact, in its 2000 filing with the U.S. Securities and Exchange Commission, ISMIE admitted that the Supreme Court's invalidation of the 1995

damages cap in *Best* had not led to a higher level of claims and that ISMIE had “continued to experience *lower claims frequency* as compared to historical patterns.”<sup>136</sup>

Now after the fourth consecutive cycle of “crisis,” it is now even more clear that the factors leading to increased medical malpractice insurance rates are insurance company business decisions, their investment income, and other economic factors - all completely unrelated to actual lawsuit and claims experience. The insurance industry’s own data show that medical malpractice claims and lawsuits in Illinois are stable - in total payouts, frequency and severity.

In truth, the medical profession has had many exclusive and special legal protections since 1985, just a few of which are:

- A doctor’s certificate of merit is required to file a lawsuit.
- Punitive damages are abolished.
- Plaintiffs’ (but not defense) attorneys’ fees are limited by statute.
- Periodic payments of verdicts can be chosen by an insurer.

Before passage of the 2005 cap, its proponents had requested and agreed to several other unique protections under the law, only a few of which were eventually included in the law. The proponents admitted that *none of these provisions would have any meaningful impact upon the issues at hand.*<sup>137</sup>

In sum, malpractice insurance rates may be high, but claims and lawsuits are not the root causes of these insurance “crises.” Let’s not be fooled again.

## Conclusion

In the run-up to the 2005 cap legislation, special interest groups yet again made unsupported, if not outright false, assertions that increases in claims and excessive awards by “runaway” juries in “judicial hellholes” were causing higher malpractice insurance rates. The special interests also alleged that doctors were “fleeing” Illinois in droves and that malpractice cases were increasing the cost of health care. These misrepresentations entered the debate as proven fact, were repeated without fact-checking or attribution, and left the debate in the form of parroted legislative findings.

In truth, claims, lawsuits, and payouts have all been stable or declining, and are not responsible for increases in doctors’ malpractice insurance rates. Nor have claims and lawsuits caused a shrinkage of physician supply or an increase in the costs of health care.

It is time for the public debate to focus on fact rather than fiction, on the need for true insurance reform and improved patient safety rather than irresponsible fear-mongering about the justice system.

## NOTES

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<sup>1</sup> Illinois State Medical Inter-Insurance Exchange (“ISMIE”), a mutual insurance company, has long been the dominant medical malpractice insurer, insuring approximately 60 percent of the physicians in the state. Its campaign for a cap had a slick public relations component, called “Reality Medicine.”

<sup>2</sup> Edward J. Kionka, *Things To Do (Or Not) To Address The Medical Malpractice Insurance Problem*, 26 N. Ill. L. Rev. 469, 471 (2006).

<sup>3</sup> *Lebron v. Gottlieb Mem. Hosp.*, Docket Nos. 105741, 105745 cons., slip op. at 23 (Ill. Feb. 4, 2010).

<sup>4</sup> *Lebron v. Gottlieb Mem. Hosp.*, Docket Nos. 105741, 105745 cons., slip op. at 25 (Ill. Feb. 4, 2010).

<sup>5</sup> *Lebron v. Gottlieb Mem. Hosp.*, Docket Nos. 105741, 105745 cons., slip op. at 24 (Ill. Feb. 4, 2010).

<sup>6</sup> Illinois Dept. of Financial and Professional Regulation, Division of Insurance, *In the Matter of the Medical Malpractice Rate Increase of ISMIE Mutual Insurance and ISMIE Indemnity Company* (available at <http://www.idfpr.com/DOI/pressRelease/pro5/110905MM.pdf>) (hereinafter “ISMIE Rate Hearing”) (Nov. 9, 2005, pp. 5-6, 17)

<sup>7</sup> ISMIE Annual Statements filed with Division of Insurance, 1998-2005, Supplement “A” to Schedule T.

<sup>8</sup> ISMIE Rate Hearing, Nov. 9, 2005, pp. 60, 63 (Conway) (emphasis added).

<sup>9</sup> Public Citizen, *The 0.6 Percent Bogeyman*.

<sup>10</sup> “I’m A Doctor. So Sue Me. No. Really.”, Rahul K. Parikh, MD, Salon.com, October 28, 2009.

<sup>11</sup> Lewis L. Laska, Ph.D and Katherine Forrest, M.D., *Faulty Data and False Conclusions: The Myth of Skyrocketing Medical Malpractice Verdicts* (June 2003).

<sup>12</sup> Geoff Boehm, *Debunking Medical Malpractice Myths: Unraveling the False Premises Behind “Tort Reform,”* 5 Yale J. Health Policy L. & Ethics 357, 358 (2005).

<sup>13</sup> ISMIE Rate Hearing, September 27, 2005, pp. 20-21, 24, 236.

<sup>14</sup> ISMIE Rate Hearing, Sept. 27, 2005, p.236.

<sup>15</sup> ISMIE Rate Hearing, November 9, 2005, pp. 31-34, 41.

<sup>16</sup> December 15, 2005, letter from ISMIE to Michael McRaith, Director, Illinois Dept. of Insurance, p. 5.

<sup>17</sup> ISMIE Rate Hearing, November 9, 2005, p. 28.

<sup>18</sup> *Public Citizen, The 0.6 Percent Bogeyman*.

<sup>19</sup> February 5, 2004 letter from ISMIE to Senator William Haine, et al.

<sup>20</sup> ISMIE Rate Hearing, November 9, 2005, pp. 28-29, 50-52.

<sup>21</sup> Order of Department of Financial & Professional Regulation – Division of Insurance, March 14, 2006, ¶10-12.

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<sup>22</sup> Bradley C. Strunk, Paul B. Ginsburg, John P. Cookson, “Tracking Health Care Costs: Spending Growth Stabilizes at High Rate in 2004,” Data Bulletin No. 59, Center for Studying Health Care System Change (June 2005) (available at <http://www.hschange.org/CONTENT/745>).

<sup>23</sup> March 15, 2004, letter from ISMIE to Senator Don Harmon.

<sup>24</sup> James Tierney, ISMIE’s lobbyist, testified in the House Judiciary Committee on March 8, 2005, that whatever pressures were driving the rate increases in 2003 had lessened in 2004. He overstated the average indemnity payment in 2003 as \$589,000 (vs. \$535,000). (Mar. 8 hearing at 76). He also testified that the average indemnity “may have declined in 2004 for the first time in a long time by single digits,” when in fact, there had been a decline only three years earlier, in 2001. (Mar. 8 hearing at 77-78). In a press release on April 6, 2005, ISMIE again overstated its average indemnity payment for 2003 as \$589,000 and as \$556,000 in 2004. In an April 7, 2005, article in the *Chicago Sun Times*, ISMIE was quoted as saying that its average indemnity payment was \$556,000 in 2004, and repeated Tierney’s statement that the average indemnity payment had dropped “6 percent” from 2003. ISMIE misrepresented the actual decline in average claim payments and never mentioned that there was a decrease of 10 percent on its total payouts in 2004.

<sup>25</sup> ISMIE Rate Hearing, September 27, 2005, pp. 26, 60, 64-69, 71-74, 77, 139, 143-146; November 9, 2005, pp. 232-235.

<sup>26</sup> ISMIE Rate Hearing, September 27, 2005, pp. 70-72.

<sup>27</sup> ISMIE Rate Hearing, November 9, 2005, pp. 233-234.

<sup>28</sup> ISMIE Rate Hearing, September 27, 2005, p. 236.

<sup>29</sup> ISMIE Rate Hearing, September 27, 2005, pp. 20-21, 24, 236.

<sup>30</sup> *Medical Malpractice and the Tort System in Illinois; A Report to the Illinois State Bar Association*, Neil Vidmar, Ph.D., American Medical Association, Physicians Characteristics and Distribution in the US, 2005 Edition).

<sup>31</sup> *Id.*

<sup>32</sup> *Chicago Daily Law Bulletin*, June 10, 2003.

<sup>33</sup> ISMIE has not publicly released county by county data since 2004 .

<sup>34</sup> *Belleville News Democrat*, July 18, 2004.

<sup>35</sup> *Belleville News Democrat*, July 18, 2004.

<sup>36</sup> February 5, 2004 letter from ISMIE to Senator William Haine, et al.

<sup>37</sup> *Id.*

<sup>38</sup> Management’s Discussion and Analysis, 2002 ISMIE Annual Statement..

<sup>39</sup> *Crain’s Chicago Business*, April 10, 2008.

<sup>40</sup> *Belleville News Democrat*, January 1, 2006.

<sup>41</sup> *Id.*

<sup>42</sup> *Crain’s Chicago Business*, March 20, 2006.

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<sup>43</sup> “Rebels Take Aim at ISMIE,” *Crain’s Chicago Business*, Mar. 28, 2005, p. 8.

<sup>44</sup> *Id.*

<sup>45</sup> Geoff Boehm, *Debunking Medical Malpractice Myths: Unraveling the False Premises Behind “Tort Reform,”* 5 *Yale J. Health Policy L. & Ethics* 365 (2005).

<sup>46</sup> House Judiciary Hearing,, Mar. 1, 2005, at 7 (Manna testimony); Senate proceedings, Mar. 1, 2005, at 33.

<sup>47</sup> ISMIE Holdings Inc., Amendment No. 3 to Form S-4, Registration Statement Under the Securities Act of 1933 filed with SEC (Feb. 14, 2000).

<sup>48</sup> E.g., ISMIE Rate Hearing, Sept. 27, 2005 pp. 95-96 (“we just missed the rates that were needed”); Nov. 9, 2005, pp. 18-19 (Washburn) (“we did not have the rates correct in previous years, and because of that, the rate increases had to be dramatic when it came to be 35 percent.”).

<sup>49</sup> *Id.* at 229 (“in 2002 [ISMIE] discovered [its] reserves were deficient” and had to increase premium rates).

<sup>50</sup> ISMIE Rate Hearing, September 27, 2005, p. 54.

<sup>51</sup> House Judiciary Hearing, Mar. 1, 2005, p.62 (Angoff testimony); Senate Judiciary Committee Hearing, Mar. 10, 2005, p. 33 (Manna testimony).

<sup>52</sup> ISMIE Rate Hearing, Nov. 9, 2005, pp. 150-51.

<sup>53</sup> House Judiciary Hearing, Apr. 7, 2005, pp. 41 (D’Arcy testimony).

<sup>54</sup> Thomas Baker, *The Medical Malpractice Myth* 53-54 (2005).

<sup>55</sup> Bernard Black, Charles Silver, et al., “Stability, Not Crisis: Medical Malpractice Claim Outcomes in Texas, 1988-2002,” 2 *J. Empirical Legal Stud.* 207, 210 (July 2005).

<sup>56</sup> The maximum premiums for corporate/entity policies rose in the 2006-2007 policy year to 25 percent of the sum of the five highest premiums for physicians within the entity. Previously the maximum premium was calculated as the average of the five highest physician premiums. ISMIE also prohibited physicians from dropping the corporate coverage.

<sup>57</sup> Dr. Ellen Brull, quoted in “Doctors’ Insurer Sees Profit Soar,” *Crain’s Chicago Business*, Apr. 14, 2007.

<sup>58</sup> “Med-mal Insurer Sees Claims Fall,” *Crain’s Chicago Business*, Mar. 20, 2006.

<sup>59</sup> House Judiciary Hearing, Feb. 23, 2005, p. 92 (testimony of Max Brown of Rush Univ. Hospital.).

<sup>60</sup> *Chicago Tribune*, December 12, 2004.

<sup>61</sup> “Suddenly Insurers Covet Illinois Docs,” *Crain’s Chicago Business*, Nov. 25, 2006.

<sup>62</sup> *St. Louis Post-Dispatch*, August 18, 2008.

<sup>63</sup> “Suddenly Insurers Covet Illinois Docs,” *Crain’s Chicago Business*, Nov. 25, 2006.

<sup>64</sup> *Illinois Issues*, March 2008.

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<sup>65</sup> The ABA House of Delegates adopted a resolution to that effect in Feb. 1989. The ABA testified most recently on October 8, 2009 on McCarran-Ferguson Act reform before the House Judiciary Committee, Subcommittee on Courts and Competition Policy.

<sup>66</sup> The Foundation for Taxpayer and Consumer Rights, *How Insurance Reform Lowered Doctors' Medical Malpractice Rates in California and How Malpractice Caps Failed*.

<sup>67</sup> Source: California Department of Insurance

<sup>68</sup> "New Data Shows Tort Law Changes Won't Reduce Malpractice Premiums," available at [www.justice.org/clips/premiums2009.pdf](http://www.justice.org/clips/premiums2009.pdf).

<sup>69</sup> *Id.*

<sup>70</sup> *Id.*

<sup>71</sup> *Id.*

<sup>72</sup> Martin D. Weiss, Ph.D, et al., *Medical Malpractice Caps: The Impact Of Non-Economic Damage Caps on Physician Premiums, Claims Payout Levels, and Availability of Coverage at 3* (June 3, 2003).

<sup>73</sup> House Judiciary Hearing, February 23, 2005, p. 72 (Hard testimony).

<sup>74</sup> Kinney, et al., *Indiana's Medical Malpractice Act: Results of a Three-Year Study*, 24 *Ind. L. Rev.* 1275, 1286 (1991); see also David Morrison, *In Search of Savings: Caps on Jury Verdicts Are Not a Solution to Health Care Crisis*, 7 *Loy. Consumer L. Rep.* 141, 149 (1995) (showing that Indiana's cap on damages has not resulted in a savings for health care consumers).

<sup>75</sup> Donald J. Zuk, chief executive of SCPIE Holdings, Inc., a leading malpractice insurer in California, *Wall Street Journal*, June 24, 2002.

<sup>76</sup> Medical Professional Liability, State of Florida, St. Paul Fire and Marine Insurance Company, St. Paul Mercury Insurance Company.

<sup>77</sup> Study Finds No Link Between Tort Reforms and Insurance Rates, *Liability Week*, July 19, 1999.

<sup>78</sup> "Tort Reforms Don't Cut Liability Rates" *Business Insurance*, July 19, 1999) (paraphrased).

<sup>79</sup> Ed Murnane, *Chicago Daily Law Bulletin* Tort Reform Summit, May 17, 2005.

<sup>80</sup> Dept. of Financial and Prof. Regulation, Division of Insurance, Order, In the Matter of the Medical Malpractice Rate Increase of: ISMIE Mutual Insurance Company (available at <http://www.idfpr.com/DOI/pressRelease/pro6/03142006ISMIEDecision.pdf>). See also "Insurance Department Orders Rate Breaks for Many Illinois Doctors," *Chicago Defender*, Mar. 15, 2006, at 2; Steven R. Strahler, "Med-Mal Insurer Sees Claims Fall; Profit and Executive Pay Rose at ISMIE in 2005," *Crain's Chicago Business*, Mar. 20, 2006, at 2.

<sup>81</sup> House Judiciary Hearing, Mar. 8, 2005, p. 81 (Kane testimony).

<sup>82</sup> *Id.* at 59-68 (Hebeisen testimony); "Caps on Damages Protect Insurers at the Expense of Those Injured or Killed by Medical Malpractice: The Patients' Perspective" (2005), at 8-11 (submitted to General Assembly and available in the Supplemental Appendix (pp. 209-12) of Plaintiffs-Appellees in *Lebron v. Gottlieb Memorial Hospital*, Nos. 105741 & 105745 (Ill. S. Ct.)).

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<sup>83</sup> *Crain's Chicago Business*, Apr. 7, 2008, at 31-32.

<sup>84</sup> *Crain's Chicago Business*, Apr. 7, 2008, at 31-32.

<sup>85</sup> *Crain's Chicago Business*, November 16, 2009

<sup>86</sup> "Risk Management Changes Improve Health Care Delivery," *Business Insurance*, April 28, 2008, at 11.

<sup>87</sup> "Risk Management Changes Improve Health Care Delivery," *Business Insurance*, April 28, 2008, at 11.

<sup>88</sup> *Crain's Chicago Business*, February 18, 2008.

<sup>89</sup> *Crain's Chicago Business*, August 25, 2008.

<sup>90</sup> "Betting On Baby," *Crain's Chicago Business*, Oct. 8, 2007.

<sup>91</sup> *Chicago Tribune*, "Bid For Hospital Offers New Site", November 26, 2009

<sup>92</sup> *Crain's Chicago Business*, September 8, 2008.

<sup>93</sup> *Chicago Tribune*, "Hospital Preps For New Facility", December 15, 2009

<sup>94</sup> *Crain's Chicago Business*, November 30, 2009; April 9, 2008; October 2, 2006.

<sup>95</sup> *Medical Malpractice and the Tort System in Illinois; A Report to the Illinois State Bar Association*, Neil Vidmar, Ph.D., American Medical Association, Physicians Characteristics and Distribution in the US, 2005 Edition); Amicus Curiae Brief of Professor Neil Vidmar, et al., in *Lebron*.

<sup>96</sup> *Id.*

<sup>97</sup> *Id.*

<sup>98</sup> *Medical Malpractice and the Tort System in Illinois; A Report to the Illinois State Bar Association*, Neil Vidmar, Ph.D., American Medical Association, Physicians Characteristics and Distribution in the US, 2005 Edition); Amicus Curiae Brief of Professor Neil Vidmar, et al., in *Lebron*.

<sup>99</sup> *Medical Malpractice and the Tort System in Illinois; A Report to the Illinois State Bar Association*, Neil Vidmar, Ph.D., American Medical Association, Physicians Characteristics and Distribution in the US, 2005 Edition); Amicus Curiae Brief of Professor Neil Vidmar, et al., in *Lebron*.

<sup>100</sup> *Medical Malpractice and the Tort System in Illinois; A Report to the Illinois State Bar Association*, Neil Vidmar, Ph.D., American Medical Association, Physicians Characteristics and Distribution in the US, 2005 Edition); Amicus Curiae Brief of Professor Neil Vidmar, et al., in *Lebron*.

<sup>101</sup> "Caps Or No, Illinois Adds To Doc Totals," *Crain's Chicago Business*, Sept. 12, 2005.

<sup>102</sup> *Medical Malpractice and the Tort System in Illinois; A Report to the Illinois State Bar Association*, Neil Vidmar, Ph.D., American Medical Association, Physicians Characteristics and Distribution in the US, 2005 Edition); Amicus Curiae Brief of Professor Neil Vidmar, et al., in *Lebron*.

<sup>103</sup> "Caps Or No, Ill, Adds To Doc Totals," *Crain's Chicago Business*, Sept. 12, 2005.

<sup>104</sup> *Id.*

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<sup>105</sup> *Id.*

<sup>106</sup> *Id.*

<sup>107</sup> Fred J. Hellinger & William E. Encinosa, *The Impact of State Laws Limiting Malpractice Awards on the Geographic Distribution of Physicians* (2003).

<sup>108</sup> Marc Rodwin, "Malpractice Premiums and Physicians' Income: Perceptions of a Crisis Conflict with Empirical Evidence," 25 *Health Affairs* 750 (May/June 2006).

<sup>109</sup> *And Then There Were None-The Coming Physician Supply Problem*, California Medical Association, 2001.

<sup>110</sup> A Longitudinal Analysis of the Impact of Liability Pressure on the Supply of Obstetrician-Gynecologists, Y. Tony Yang, David M. Studdert, S.V. Subramanian, and Michelle M. Mello, *Journal of Empirical Legal Studies*, Volume 5, Issue 1, 21-53, March, 2008.

<sup>111</sup> *New York Times*, June 5, 2009.

<sup>112</sup> *Chicago Tribune*, May 1, 2005

<sup>113</sup> Although the Medical Society and hospitals have never publicly disclosed the names on the "list," perhaps some of the following would (or should) have been on it:

**Michael S. Schiff, Alton** – license indefinitely suspended for failing to pay Illinois income taxes for 2000.

**T. Bruce Vest, Godfrey** - license revoked for a minimum of 5 years in 2001 due to conviction of a felony, failing to report his exclusion from the Medicare program, and committing gross negligence in the treatment of one patient.

**Terrence Tyrrell, Belleville** – reprimanded for allegedly misinterpreting a mammogram.

**Richard Kaminsky, Belleville** – indefinitely suspended for failing to undergo a mental and physical examination as ordered by the Medical Disciplinary Board.

**James Probst, Swansea** – license placed on probation until Nov. 13, 2006, for diverting controlled substances and license reprimanded after testing positive for Darvocet while on probation for addiction to alcohol and controlled substances.

**Tanin Parich, Alton** – reprimanded for refilling a kidney transplant patient's medications without consulting with the patient's nephrologists.

**Walt Mutschler, Glen Carbon** – placed on probation for five years due to the habitual use of drugs and/or alcohol.

**Srinivasarao Yaganti, Belleville** – placed on probation for two years for improperly touching a patient.

**Elizabeth Wuebbels, Highland** – license placed on indefinite probation for prescribing controlled substances to an acquaintance for non-therapeutic use, and addiction to alcohol.

**Farooq K. Ghory, Mt. Vernon** – license temporarily suspended pending proceedings before the Medical Disciplinary Board after being disciplined in Kentucky for engaging in inappropriate sexual conduct with multiple patients and for non-therapeutically prescribing controlled substances in exchange for sexual favors.

**Christopher A. Rice, DuQuoin** - probation for violating care, counseling and treatment agreement.

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**Kwangsup S. Kim, St. Louis, MO** - Kim agreed to apply to renew his medical license after he allegedly breached the standard of care in examining female patients.

<sup>114</sup> Ann Kneff, *Granite City Woman Files Med Mal Suit Against Petrovich*, The Madison St. Clair Record, January 31, 2006, <http://madisonrecord.com/news/174056-granite-city-woman-files-med-mal-suit-against-petrovich>.

<sup>115</sup> Congressional Budget Office, Economic and Budget Issue Brief: Limiting Tort Liability for Medical Malpractice (Jan. 8, 2004), at 1 (“CBO 2004”).

<sup>116</sup> Congressional Budget Office, Budget Options Volume 1: Health Care (Dec. 2008), at 22 (“CBO 2008”).

<sup>117</sup> CBO 2004, at 1.

<sup>118</sup> *Id.* at 5.

<sup>119</sup> *Id.* at 1.

<sup>120</sup> *Id.* at 6.

<sup>121</sup> Congressional Budget Office, Background Paper: “Medical Malpractice Tort Limits and Health Care Spending.” (April 2006).

<sup>122</sup> CBO 2008, at 21.

<sup>123</sup> *Id.*

<sup>124</sup> Darius Lakdawalla and Seth Seabury. “The Welfare Effects of Medical Malpractice Liability,” NBER Working Paper No. 15383. September 2009.

<sup>125</sup> Ronen Avraham, Leemore Dafny, and Max Schanzenbach. “The Impact of Tort Reform on Employer-Sponsored Health Insurance Premiums,” NBER Working Paper No. 15371. September 2009.

<sup>126</sup> Frank Sloan and John Shadle. “Is there empirical evidence for “Defensive Medicine”? A reassessment,” *Journal of Health Economics*. Vol 28, Issue 2. March 2009. Pg 481-491.

<sup>127</sup> Katherine Baicker and Amitabh Chandra, The Effect of Malpractice Liability on the Delivery of Health Care, National Bureau of Economic Research Working Paper 10709, at 20 (Aug. 2004).

<sup>128</sup> *Id.*

<sup>129</sup> *St. Louis Post-Dispatch*, September 14, 2009

<sup>130</sup> Congressional Budget Office, *Key Issues*, pp. 150-154, December 2008.

<sup>131</sup> Testimony before U.S. House Ways and Means Committee, September 10, 2002.

<sup>132</sup> *Saving Lives and Saving Money*, Gingrich Communications 2003.

<sup>133</sup> *Journal of the American Medical Association (JAMA)*

<sup>134</sup> Increasing Risk, Hurting Patients- Shirley Svorny (from the Cato Institute) - Forbes, November 2, 2009

<sup>135</sup> *id.*

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<sup>136</sup> ISMIE Holdings Inc., Amendment No. 3 to Form S-4, Registration Statement Under the Securities Act of 1933 filed with SEC (Feb. 14, 2000) at 54 (emphasis added).

<sup>137</sup> House Judiciary Hearings- April 14, 2005, pp. 127-128,133, 137-147; April 7, 2005, pp. 131-132, 134-136; March 8, 2005, pp. 56-57; March 1, 2005, pp. 100-102.

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