

NC Medical Malpractice Insurance Data v. Plaintiffs' Attorneys

Can Fact Prevail Over Fiction?

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THE 2003 DEBATE over tort reform in the NC Legislature has pitted the plaintiffs' attorneys primarily against the medical malpractice insurers, not the physicians—a strategic ploy by attorneys who make their living suing physicians. The strategy is quite simple: to convince the legislators who vote for reform that the prevailing tort problems are not caused by the state's physicians but, rather, by the companies that insure the physicians. Thus a legislator's "no" vote on reform measures would offend only the insurance companies, which do not vote, not the physicians, who do—a less problematic result for elected officials. Call it the "dehumanization" of the tort reform debate. Effective? You bet. The litigation status quo is thereby maintained, and the plaintiffs' attorneys leave Raleigh having preserved their very lucrative income streams: no caps on damages, no caps on attorney fees, no change to the collateral source rule. Life is good—for the attorneys, but not for the physicians and their patients.

Make no mistake, suing physicians has become big business for many North Carolina attorneys. These attorneys, however, have a real dilemma. On the one hand, they argue against any limitations on awards for medical malpractice because to do so will reduce or eliminate the "litigation deterrent" to the bad medicine that they allege is rampant in the state. On the other hand, they offer no solutions for improving the alleged "dismal care," because to do so would eliminate the bases upon which they sue.

Cynical? Perhaps, but at the heart of the debate are very credible data from the insurers of physicians, showing that reform is needed. Without reform, North Carolina will lose excellent physicians and its citizens will find it increasingly difficult to get access to certain specialists. Physicians will stop seeing those patients (or reduce the number of patients they will see) who either are uninsured or are insured through the lowest reimbursement programs. The quality of healthcare will diminish. It has happened and is happening throughout the country; now it has begun to happen in North

Carolina. There is no reason to believe that North Carolina is unique in its ability to ward off these natural outcomes from escalating medical malpractice exposure. Physicians are facing unaffordable insurance premiums and, in the near future, some specialties will be unable to find insurance at any price.

Plaintiffs' attorneys counter by blaming the insurers. They have a very vested interest in doing so, because this shifts the debate to exactly where they want it.

The following discussion and presentation of data shows the reality of the malpractice problems facing North Carolina's physicians. (All data come from MMIC's own database of policy-holder information, which is used to generate both the audited financial statements of Medical Mutual Insurance Company of North Carolina and the Annual Statements of Medical Mutual Insurance Company of North Carolina—the "Yellow Book"—filed with the North Carolina Department of Insurance. All statements are independently audited by Ernst & Young.)

Unless addressed through reform, these problems will become real for patients, too. The blame placed on malpractice insurers for these problems by plaintiffs' attorneys is factually baseless. Their advocacy has deteriorated and has become more fiction than fact. The "fictions" discussed (and rebutted) below have become the mantra of the plaintiffs' attorneys in opposing tort reform in Raleigh and in Washington. The time has come to focus the debate where it should be: on physicians and their patients.

Fiction #1: "Big insurance companies" milk their physician insureds for excessive premiums to generate excessive profits.

In 1976, when the commercial, professional liability insurance market effectively left the state, NC physicians started Medical Mutual Insurance Company of North Carolina

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(MMIC) with their own money. They founded the company with the goal of charging only enough in premiums to sustain a continuing, financially viable insurance market for North Carolina physicians. As its name indicates, it is a mutual company, meaning that it is owned by its physician policyholders. All but one of its Board members are physicians. There are no stock dividends paid to the physician-owners, because there are no excessive profits to fund them. There are no pressures from Wall Street to give shareholders some minimum return on equity. There is no stock price to be manipulated by premium pricing. The company serves its goal best by running its operations as efficiently as possible and by charging its owners the lowest premiums possible.

Today, Medical Mutual is the largest insurer of physicians in the state, insuring almost 6000 physicians, their staffs, and their practices. Among its peer group of 30 physician-owned insurance companies around the country, its underwriting expense ratio is the lowest in the industry, using only 12.1 cents of every premium dollar collected to cover direct operational expenses (12.1%). The simple average of the underwriting expense ratios for the peer group is 20.7%, and the simple mean is 18.3%.

It is estimated that 80% of all practicing North Carolina physicians are either insured by a mutual insurance company (like MMIC), or employed by an institution that is substantially self-insured. Either to overcharge premiums or to allow inefficient operations of such insurance programs would be inconsistent with the reasons for which these programs exist. They do neither.

Fact: Most NC physicians are not insured by "profit-hungry" corporations.

Fiction #2: Insurers have mismanaged their assets, and that is why they must charge higher premiums.

Insurance companies hire professional, nationally recognized, money advisors

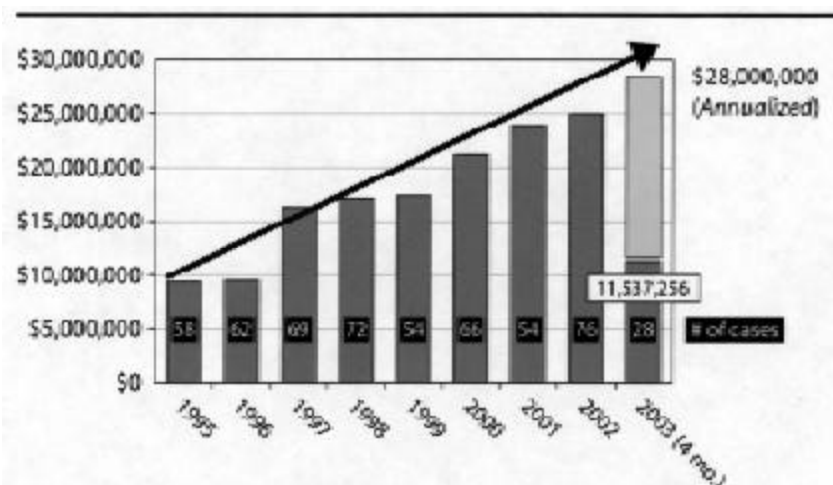


Figure 1. MMIC NC Data — Total Indemnity Paid

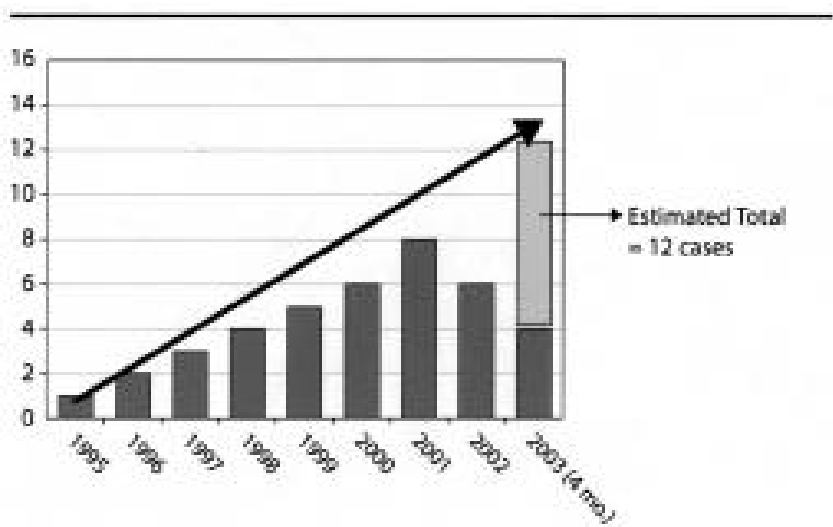


Figure 2. MMIC NC Data — Number of Indemnity Payments \$1 Million and >

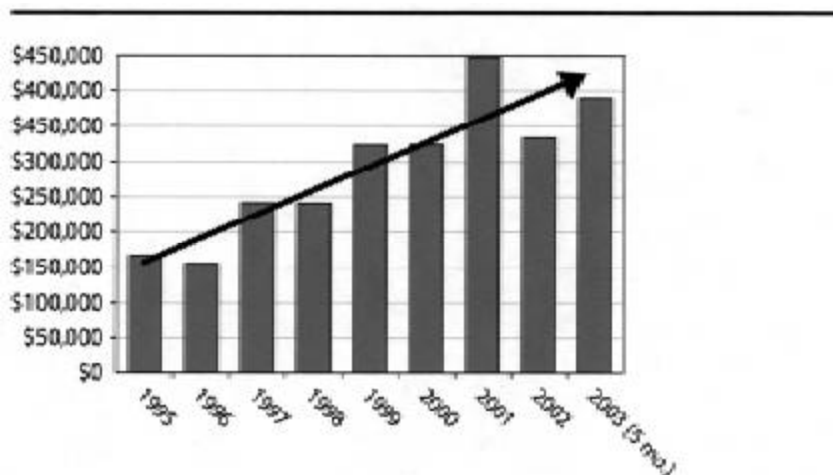


Figure 3. MMIC NC Data — Average Indemnity \$ Paid

to manage the investments of all dollars collected from premiums until they must be paid out in claims. The North Carolina Department of Insurance strictly regulates both the type and the allocation of these investments. In 2002, the overall investment return for MMIC's total securities portfolio was almost 7%, with more than 90% of its investments being in fixed income securities. The company's percentage of investments in equities has decreased from a high of 15.25% in 2000 to 7.98% in 2002. Total investment returns for the same three-year period have averaged almost six percent 6%. Because almost all of its investments are—and must be—in high-grade government and corporate bonds, financial market fluctuations have negligible impact on premium pricing. Everyone should have been so fortunate as to have earned 7% on their investments in 2002.

Fact: Malpractice premiums are not soaring because of the vagrancies of Wall Street.

Fiction #3: A significant increase in the number of claims (suggesting more medical errors) is driving the escalation in premiums.

“Frequency” is an insurance term meaning the number of claims reported in a given policy year or calendar year. “Severity” is a term used to describe the dollars paid to the patients and their attorneys. Severity, and not frequency, has driven premium costs up over the past five years. Since the number of insureds may vary on a year-to-year basis, claims reported per one hundred doctors is a standard method of annually assessing frequency. From 1998-2002, frequency per one hundred doctors has remained at around 11 claims per 100 physicians.

Figure 1 shows the total “indemnity” (dollars paid to patients and their attorneys) from 1995 through May 31, 2003. Note the upward trend line and the aggregate dollars rising from under \$10 million in 1995 to \$25 million in 2002. Figures 2 and 3 show the rising number of payments in excess of a million dollars and the average indemnity payments for the same time period – again, the trend lines are up, indicating escalating severity.

Fact: Despite claims per 100 physicians remaining steady, the payments to patients and their attorneys are escalating and causing higher premiums.

Fiction #4: Insurers have grossly under-reserved their future losses to make up for past financial performance and are playing catch-up with excessive premiums.

Reserves are the dollars that insurance companies are required by law to set aside to assure their financial ability to pay future claims. Each year, an independent actuary certifies the adequacy of MMIC's reserve amounts. In addition,

they are annually evaluated by an independent auditor, Ernst & Young. Over the past five years, MMIC has consistently reserved at or above the amounts certified by the independent actuary. Reserves as of December 31, 1998 of \$64.9 million grew to \$97.75 million at the end of 2002. This five-year reserve growth history serves as a good predictor of the escalating dollars needed to resolve future claims, and the increases in the severity of those claims reserved over that period.

Fact: MMIC's reserves are required and set at levels needed to protect its insureds from future losses.

Fiction #5: “It's just a few bad doctors causing all of the claims problems.”

A physician's claims history does not yield mature, statistically meaningful data until after that physician has been our insured for a number of years. Claims are reported over time and, once reported, can take several years to reach resolution. Of those physicians who have been insured by us for ten or more years, 45% have been sued for malpractice. In some specialties, that percentage increases; for example, 55% for Emergency Medicine, 62% for Obstetricians and 70% for General Surgeons. Those percentages do not reflect just “a few doctors.”

Almost 1000 MMIC-insured physicians in North Carolina have been sued one time, and payments to resolve claims against them are in excess of \$183 million. Three hundred twenty-five physicians have been sued more than one time, and payments to resolve claims against them are in excess of \$161 million. Based on the average number of physicians insured each year since the inception of the company, almost one-third of that total have been sued at least one time. It is evident that many physicians have been the target of many suits.

Fact: The malpractice crisis is widespread and not the result of a few “bad apples.”

Fiction #6: Over time, payments to patients and their attorneys pale in comparison to what the “big insurance companies” spend to fight all of their cases.

Suing physicians has become a “money machine” in North Carolina. The patients—and their attorneys—have done well. Figure 4 summarizes the 26-year claim payment history of MMIC: \$386 million has passed from the physician-owned company to the litigation system. Figure 5 shows the distribution of those dollars among patients, their attorneys, and defense costs. The lion's share of the payment pie—over \$344 million—goes to the patients and their attorneys.

Fact: The cost to defend MMIC's physicians pales in comparison to plaintiffs' attorney fees and costs.

Fiction #7: Over time, the total increases in physician malpractice premiums time have not been that great.

Since 1995, the base premium rate that a General Surgeon pays for medical professional liability insurance (\$1 million per claim/\$1 million aggregate) has increased by 127%, from about \$17,000 per year to almost \$40,000 per year. Physicians in Obstetrics and Gynecology have seen a 137% increase (\$40,000-\$100,000); Family Practice physicians, 115% (\$4,000-\$9,000); and Emergency Medicine physicians, 153% (\$9,000-\$24,000). The projected premium dollar increases continue their staggering upward trend over the next five years for these same representative specialties and the same coverage limits. By 2008, it is estimated that General Surgeons will be paying \$86,000 per year, Ob/Gyns \$149,000, Family Physicians \$18,000, and Emergency Medicine physicians \$57,000.

These premium increases cannot, in most instances, be passed on to or recouped from patients. Without taking significant cuts in their revenue, physicians can only absorb so much in rising premiums before they must make difficult decisions regarding the scope, breadth and location of their practices. These decisions have resulted in significant access to care issues for patients in those states hardest hit by rising liability exposures.

Fact: The malpractice crisis is causing dramatic increases in premiums, which will continue in the absence of tort reform.

Fiction #8: Tort reform proposals calling for caps on noneconomic damages unfairly harm women, children, and the elderly.

In this state and throughout the nation, the specialty most in jeopardy from a malpractice perspective is Obstetrics, which has been ravaged by the greedy tort system. If suing physicians has indeed become a money machine, suing obstetricians is the foundation upon which that machine has been built. Twenty-four percent of the total indemnity payments

• Total # of Claims	1848
• Average Indemnity Paid	\$ 186,331
• Average Expenses Paid	\$ 22,544
• Total Expenses Paid	\$ 41,660,770
• Total Indemnity Paid	\$ 344,339,655
• Total Combined Paid	\$ 386,000,425

Figure 4. MMIC Inception-to-5/31/03 NC Payment Summary

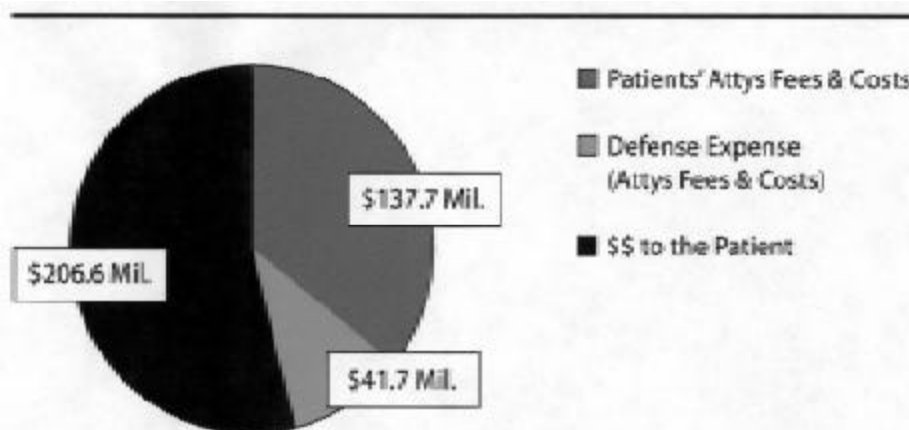


Figure 5. MMIC Inception-to-5/31/03 NC Payment Summary (where all Total Combined Paid dollars went)

of MMIC over time (\$82,375,014 out of \$334,339,655) have been paid on behalf of obstetricians. Payments greater than \$1 million per case have been made 29 times, with aggregate payments in those cases of almost \$40 million. If we include the expenses MMIC has incurred in defending all Obstetrics cases (\$7.6 million), just over \$90 million dollars has been spent on that single specialty since the inception of the company.

Ob/Gyn care touches almost every woman and child in the state. Healthcare for many women and children, and for most of the elderly, is delivered through the Medicare/Medicaid system. Medicare/Medicaid reimbursement levels are set by the government each year. On March 24, 2003, the Centers for Medicare and Medicaid Services announced that Medicare physician payments will likely be cut by 4.2% in January 2004. This would follow a 5.4% physician pay cut in 2002. In response, the AMA's Yank D. Coble, MD, stated that "[u]nder these conditions, the only way physicians can avoid payment cuts is by limiting care to our nation's elderly and disabled."

In a March report presented to the US Congress, the Medicare Payment Advisory Commission (MedPAC), expressed their concern that doctors may opt out of the program in large numbers once the 2003 cut takes effect. A

survey last year by Project Hope, on behalf of MedPAC, found the number of doctors nationwide accepting all new Medicare patients dropped from 76% in 1999 to 69% in 2002. Preliminary results from an AMA study in December 2002 showed, according to *AMNews* (February 3, 2003), that “20% of physicians limited the number of Medicare patients they saw in 2002 after a 5.4% cut in payments. Some 60% reported increased difficulty in making suitable referrals for Medicare patients. Nearly half of the physicians surveyed – including 61% of primary care physicians – said they would *reduce* the number of Medicare patients in their practices if payments are cut again in 2003.”

On March 27, 2003, *Modern Healthcare* reported that physicians’ average net income *fell* 5% in real dollars between 1995 and 1999, while at the same time average salaries for other skilled professionals *increased* about 3.5% (citing a study of about 12,000 physicians by the Center for Studying Health System Change in Washington). With decreasing physician reimbursements and decreasing physician income, it is only a matter of time before escalating malpractice premiums will seriously erode access to care for children, women, and the elderly. Malpractice insurance is a significant cost to every physician. Tort reform is needed to curb the cost escalation.

Fact: without significant tort reform women, children and the elderly will be harmed.

Conclusion

A report released by a Joint Economic Committee in Washington on May 6, 2003, entitled *Liability for Medical Malpractice: Issues and Evidence*, concluded that a \$250,000 cap

on noneconomic damages awarded in medical malpractice lawsuits, combined with other reforms, would

(1) save Medicare and Medicaid nearly \$15 billion over ten years;

(2) bring in nearly \$3 billion in taxes because employees would have less money coming out of their paychecks pretax to pay for health insurance;

(3) reduce defensive medicine by physicians because they will not be worried about lawsuits, thus saving the government an additional \$9.3 billion to \$16.7 billion by 2012;

(4) encourage quality improvement efforts to identify and reduce medical errors;

(5) stop physicians from leaving certain states because liability insurance is unaffordable or unavailable;

(6) improve the nation’s access to healthcare, especially for women, low-income citizens, and rural residents — women have been especially affected because Obstetricians have been the first to give up practice in certain states (see discussion under Fiction #7, above); and

(7) increase the number of Americans with health insurance by 3.9 million by lowering the cost of coverage.

The plaintiffs’ attorneys responded to this thoughtful and compelling study by responding that it was “fiction,” according to Carlton Carl, spokesman for the Association of Trial Lawyers of America. Yet no facts were cited by the attorneys to discredit the study’s findings.

The facts in evidence of North Carolina’s medical malpractice claims environment are compelling. Our physicians need the help of our legislature to use these facts as the basis for building the type of reform needed to assure the stability of our state’s healthcare delivery system. As the above federal study shows, the expected benefits are huge.

Isn’t it about time that facts prevail over fiction?