ISMIE Mutual Insurance Company
The Physician-First Service Insurer

Illinois State Medical Society

The Whole Truth about the "Whole Truth"

Debunking the Misinformation Employed by the Illinois Trial Lawyers Association to Fight Much-Needed Medical Liability Reform and Preserve the Status Quo

March 2010

I know you lawyers can with ease
Twist words and meanings as you please;
That language, by your skill made pliant,
Will bend to favor every client.
--John Gay, English poet and dramatist

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Introduction

In the case of *Lebron v. Gottlieb Memorial Hospital*, the Illinois Supreme Court ruled that caps on noneconomic damages in medical malpractice cases violate the Illinois Constitution. These caps had been in force since the passage of a comprehensive medical liability reform law in 2005. In response to this ruling, the Illinois Trial Lawyers Association (ITLA) released a "white paper" intended to discredit the facts that led the people of Illinois to pass comprehensive medical liability reform in the first place. This paper, titled "The Whole Truth about Medical Malpractice and Insurance," is rife with misinformation, misleading statistics and outright falsehoods. Unfortunately, the facility with words for which trial lawyers are so famous makes the document seem convincing at first glance. Fortunately, Illinois physicians refuse to give up on their patients.

In this rebuttal to the ITLA's paper, we will provide a clear and concise explanation of the workings of a medical malpractice insurance company; specifically address the charges leveled against ISMIE Mutual, Illinois' largest writer of medical malpractice insurance; and deconstruct the trial lawyers' marriage to the status quo, renewing the call for sensible reforms that will benefit Illinois physicians and their patients.

The History of ISMIE Mutual

ISMIE was founded in 1976 with the mission of providing medical malpractice insurance to Illinois physicians. This coverage is vital for every physician; dealing with the health of the human body is often an inexact science, and no other profession faces the certainty of lawsuits as medicine does. For example, a neurosurgeon in Illinois can expect to be sued once every 2.44 years, an orthopedic surgeon every 3.70 years and an obstetrician-gynecologist every 5.55 years. To ameliorate the financial burden imposed by these lawsuits, physicians buy liability (malpractice) insurance.

Prior to 1976, a number of commercial insurance companies sold medical liability insurance to Illinois physicians. In the mid-1970s, however, this business was becoming increasingly expensive – so much so that by 1976 the last remaining insurance company that sold this coverage in Illinois decided to get out of the state, leaving Illinois physicians with *zero options* for buying liability insurance. Something had to be done, and the physicians themselves did it, starting the Illinois State Medical Inter-Insurance Exchange (ISMIE). As the only insurance company willing to write policies for all specialties and in all parts of the state, ISMIE grew large very quickly. ISMIE was wholly owned by its policyholders, and although it reorganized into a mutual insurance company in 2002, it is still owned by its physician policyholders and operated by physician leadership.

The not-for-profit roots of ISMIE Mutual still guide its operations today. Because it is a mutual company, there are no stockholders that expect to make a profit. Any income not used to pay claims or cover overhead costs is used to maintain the reserves and surplus needed for an insurance company to remain financially viable in an often-unpredictable market, or distributed back to policyholders as dividends.

How Malpractice Insurance Works

What Is Malpractice Insurance?

Before we can address the accusations made by the trial lawyers, it is necessary to explain some of the principles of the insurance business. The trial lawyers rely on the complex nature of this business to create confusion and dissuade those who might question their propaganda, but Illinois patients deserve to know the whole truth. To that end, we will now briefly discuss how medical liability insurance works.

When a physician faces a malpractice lawsuit, as most will, the situation can be devastating. Even when the physician has done nothing wrong, it can take years and cost hundreds of thousands of dollars to defend against accusations of malpractice. If the physician loses the case, or even if a settlement is reached, the awards can run into the millions. Much like other forms of insurance, medical liability insurance helps cover those costs. By spreading the risk of lawsuits across its entire policyholder base and charging each policyholder a rate commensurate with the amount of risk they contribute to the pool, a malpractice insurance company can help keep individual physicians from being financially ruined by lawsuits and keep itself from going bankrupt in the process.

Each policy insures the policyholder for any amount up to the policy limit, which is usually $1 million per claim and $3 million annually. When a policyholder is faced with a potential financial loss because of a malpractice suit or settlement, a claim is filed with the insurance company. Because malpractice lawsuits are commonly filed years after the alleged malpractice occurred, insurance claims are usually made long after the treatment in question was given. Medical liability insurance, for the most part, is a “claims-made” product – the premiums paid in any given year cover claims made in that year, not necessarily claims that arise from treatment given in that year. It is extremely rare for an adverse event to occur, a claim to be filed and the claim to be resolved all in one year.

How Are Rates Set?

Insurance companies must determine their rates before any policies can be sold, but because of the years it often takes for claims to work their way through the system, it is not known for several years whether the premiums charged in a given year will cover the payments made and expenses incurred on that year's balance sheet. This might be compared with a manufacturing company setting a price for its product several years before the cost of making that product is known. As a result, insurance companies must maintain reserves to help pay for claims and surplus to provide a safety net. They also buy reinsurance to help cover costs if judgments are much larger than anticipated.

This does not mean that insurance companies blindly guess at what their rates should be. Actuaries are employed to examine all the factors at hand and all the available data in order to provide an estimate of how much the company will have to pay out, how much it will need to keep in reserve, etc. As time passes and the estimates made in setting rates for a given year can be compared with the actual numbers that emerge for that year, the insurance company's financial situation becomes clearer.

Like any corporation, insurance companies must also factor in their overhead and administrative costs when they determine their rates. Even in the volatile Illinois medical malpractice insurance market, ISMIE Mutual operates just as cost-efficiently as its competitors.

Rates are determined by formulating a base rate and making adjustments to it for each policyholder. The base rate is derived from a number of factors: the number of physicians expected to be insured, the number of claims expected to be filed, the number of filed claims that are expected to lead to an indemnity payment, the average cost of the indemnity payments themselves, the average cost of defending claims closed with indemnity payments and cost of defending claims closed without indemnity payments. Once the base rate is determined, it is adjusted for each policyholder on the basis of specialty, location of practice and how many years of prior exposure will be covered.

Here again the lag between the medical event itself and the resolution of a related claim comes into play. Most of the factors involved in calculating the base rate are not fully known until years after the base rate has been determined. In addition, because claims can be made many years after the treatment in question occurred, claims are often filed against physicians who are retired or deceased. To cover claims against these physicians and their estates, additional coverage, known as "tail coverage," is needed. ISMIE Mutual offers this coverage at no additional charge to physicians who have held policies with ISMIE for a set number of years (depending on age), as do its competitors, and so must include the actual cost of this coverage in its rate calculations.

How Are Claims Tracked?

Tracking the claims made against malpractice insurance policies is vital to the rate-setting process and the survival of the company. Unfortunately, it is not as simple as it may sound. Internal identification numbers are assigned in a wide range of circumstances, such as when a physician gives a deposition in a civil case or is served a subpoena. Some of these instances develop into actual claims, but others do not; these identification numbers are simply a tracking mechanism. When setting rates, ISMIE actuaries are careful to exclude these circumstances that do not reflect lawsuits against physicians, meaning that only actual claims are used in rate-setting.

Two important terms that are used in reference to insurance claims are "frequency" and "severity." Frequency describes the number of claims filed against policyholders in a given year, and severity describes the average amount paid out by the insurance company in response to those claims. Recent trends in frequency and severity are of primary importance to actuaries as they determine insurance rates; increases in frequency and/or severity of claims represent increased risk, and rates must be adjusted accordingly. Again, the long time between the filing of a claim and the resolution of that claim means that these trends are difficult to read – the more recent the data, the less accurate it will be. As a result, while insurance companies strive to make accurate predictions based on their actuarial data, it can take years to adjust if frequency and severity figures differ significantly from their expected levels.

The Whole Truth about the "Whole Truth"

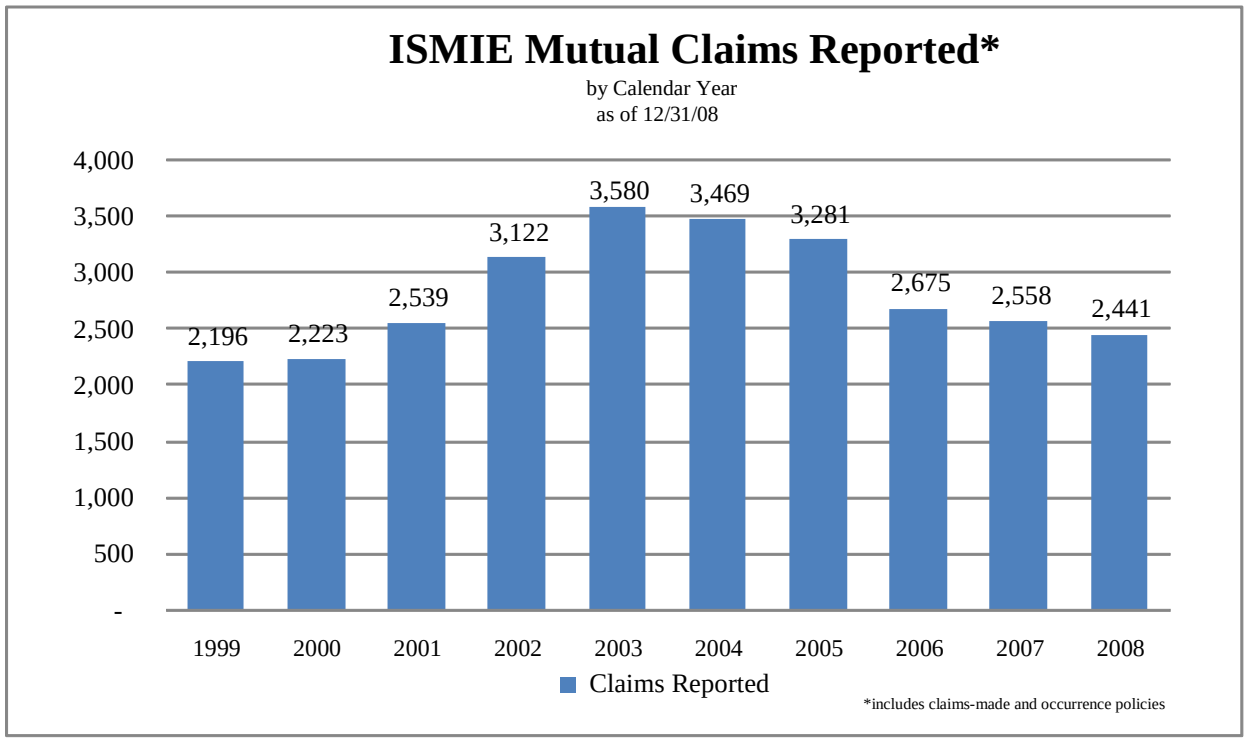
Now that we have laid a foundation of how medical liability insurance works, we can move on to addressing the abundant misinformation found in the ITLA's white paper. The trial lawyers have picked out isolated statistics that seem to support their case, but upon closer examination the figures they use are very misleading. Many of the statements they make are simply untrue. Here is a claim-by-claim examination of the ITLA's statements, where they are found and the contrasting truths that expose the trial lawyers' agenda of preserving the status quo.

"The Medical Malpractice 'Lawsuit Crisis' is a Myth" (p. 2)

This is the first of the ITLA's major claims. Because the lawsuit crisis is what led the Illinois legislature to enact the liability reforms that cut into the trial lawyers' profits, the trial lawyers have a financial interest in painting this crisis as an overblown hoax. The people of Illinois knew better in 2005, they know better now and we are here to prove it.

"Frequency was stable or decreasing" (p. 4)

The trial lawyers begin by stating that the claims ISMIE paid each year had been steadily decreasing prior to the enactment of medical liability reform in 2005. However, as we have established above, it often takes many years for claims to be paid once they are made. The relevant statistic is not how many claims are *paid* in a given year; it is how many claims are *made* in a given year. When we look at the data that actually have meaning for this discussion, a picture emerges that is much different from the one the trial lawyers would like their readers to see:



As this chart shows, reported claims went from under 2,200 in 1999 to nearly 3,600 in 2003. This drastic increase in frequency not only impacted ISMIE's rates, it also impacted many commercial insurance companies in Illinois. Some of these companies were declared insolvent because their reserves were not sufficient to absorb this increase in risk and others that survived restructured their business away from the medical liability market. As a result of its commitment to Illinois physicians, ISMIE continued writing policies in all areas and in all specialties.

Another misleading statistic picked out by the trial lawyers is that the ratio of claims closed with indemnity to total closed claims has been relatively flat since 2000. In light of the information above, the problem with this is clear: even though this ratio has been relatively flat, the fact that the total number of claims has increased means that *the number of claims closed with indemnity has also increased.* The fact that medical malpractice payouts have been declining nationwide, also cited by the ITLA, has no significant bearing on Illinois. Nationwide statistics are cited many times throughout the ITLA's paper, but these statistics do not provide an accurate picture of what is happening in Illinois.

As if all this weren't bad enough, the next statistic cited by the ITLA is that the number of medical malpractice lawsuits filed each year had been stable and then decreased before the enactment of liability reform in 2005. Even if the trial lawyers could be excused for some of their other errors, in this case they certainly know better. ISMIE's concern is not with how many medical malpractice lawsuits are filed; it is with how many individual policyholders are sued.

A single lawsuit can name as many defendants as the plaintiff wants. A given malpractice suit related to one medical episode can be filed against every doctor who came into contact with the patient over a period of years. This can result in a multitude of individual claims against individual policies, each of which has its own coverage limit and its own level of risk for ISMIE – all in a single lawsuit. This, again, is why ISMIE looks at the number of claims reported.

<u>"Severity was also stable, or even decreasing" (p. 8)</u>

ISMIE Mutual data clearly shows that not only was the average frequency of claims increasing; the severity of those claims was also on a steady rise in the years leading up to the passage of the medical liability reform law. Once again, these data are taken directly from ISMIE's annual reports, which are public documents.

After the law was enacted, the frequency of claims steadily declined, but severity has continued an upward trend, as none of the claims considered since 2005 were limited by the cap on non-economic damages. This is because the injuries in question occurred before the enactment of the liability reform law in August of 2005 – again demonstrating the long period of time that usually lies between alleged malpractice and the closing of a claim.

YEAR	AVERAGE INDEMNITY (SEVERITY)
1999	$419,034
2000	$480,062
2001	$473,917
2002	$557,374
2003	$589,829
2004	$556,191
2005	$540,089
2006	$625,277
2007	$601,041
2008	$643,266

"Insurance Rates are a Function of Industry Practices and General Economic Factors" (p. 15)

Among the many "don't blame us" arguments offered by trial attorneys is that Illinois' liability crisis is a byproduct of the "insurance cycle." These cycles of growth and decline are not uncommon in the casualty insurance business, especially where there is such a long period of time between a medical event (in the case of medical liability insurance) and the resolution of a claim related to that event. This is why this type of insurance is known as a "long-tail" line.

ISMIE's rates are not a function of market conditions and general economic factors. ISMIE follows the standard industry practice of using actuarial data to determine rates and that is all there is to it. ISMIE is a conservatively managed company, operating in no other lines of insurance business beside medical liability. Cycles are not the root of the problem here. It is the abundance of lawsuits and escalating payouts, as evidenced in the charts above, that is responsible for the long-term rise in insurance rates.

"'Judicial Hellholes' Are Another Myth" (p. 11)

Illinois has a long and sad history on the annual "Judicial Hellholes" list, which tracks jurisdictions that heavily favor plaintiffs. Cook and Madison counties were inaugural members of the list and have made many appearances on annual updates, and St. Clair County has been on the "Watch List" many times. ITLA's claim that the rankings have no validity is extremely suspect, considering that even members of the judicial community in these areas grew weary of this dubious distinction, working to implement changes that made their courts more balanced.

Madison County's Chief Judge adopted several judicial rule changes to help stem the steady flow of medical liability cases. Even the judges who presided over cases in these notorious courts recognized there a lawsuit problem and took steps to fix it.

As ISMIE Mutual has gone about setting insurance rates for its policyholders in these areas, its actuaries have had to look long and hard at the risks involved with insuring physicians in these plaintiff-friendly jurisdictions. They have not had to look long and hard for examples of these risks, however; they are found next to some very large numbers written in red ink on ISMIE balance sheets.

In one such case, an emergency room physician cared for an automobile accident victim. Some elevated diagnostic test results were noted concerning his renal function and high blood pressure. The physician, based upon this limited encounter, could not tell if this was due to the trauma of the accident or something more long-term. Upon discharging the patient the physician instructed the patient that he needed to see his own doctor within the next month for follow-up tests. The importance of this was emphasized to the patient and noted in the discharge record. Nonetheless, the patient never bothered to see his own physician. He moved to another state for some time, and a couple of years later, after experiencing new symptoms, he underwent dialysis and a kidney transplant.

Even though this patient completely failed to follow the emergency room physician's clear instructions, he sued the emergency room physician. He was awarded $8 million by a St. Clair County jury. The simple truth is that ISMIE has higher rates for several counties as it sees more claims and higher verdicts from those areas.

"ISMIE inflated the average numbers to generate phony hysteria…" (p. 9)

This statement was not made as a major point of the ITLA's argument, but it serves here as an illustration of the overall portrayal of ISMIE found in the white paper. The numerous allegations and implications made against ISMIE throughout the paper are based on information taken out of context and myriad misrepresentations of ISMIE's business practices and the insurance market. These implications are especially unjust considering the dedication ISMIE has displayed to Illinois physicians and patients; while other companies have come and gone from the Illinois medical liability insurance market, ISMIE has continued to write policies in all specialties and in all areas of the state since the day it opened its doors.

"Medical Malpractice Insurance Rate Increases Resulted in Record Profits…" (p. 13)

ISMIE's net income is used to build reserves and surplus, both of which keep the company financially stable and able to pay for future claims and operating expenses. When ISMIE's net income is more than is needed even for these purposes, the company distributes dividends to its policyholders; $37 million has been distributed to ISMIE policyholders to date.

It is worth remembering that even in the volatile Illinois medical liability insurance market, ISMIE operates just as cost-efficiently as its competitors. It is also important to note that there have been many times in ISMIE's history that it has experienced significant *net losses* rather than income; from 2003 to 2007, ISMIE had to put a moratorium on new business because its capital was insufficient to cover the risk of more policyholders. Even in more recent years, when ISMIE has experienced a positive net income, the trial lawyers' characterization of this income as "record profits" is disingenuous; ISMIE's income numbers do not hold a candle to the profits of many of its commercial competitors, and even so, ISMIE's income is used to keep premiums *down* for policyholders in the long term.

"All of [ISMIE's] risk in excess of $500,000 is transferred to the reinsurer…" (p. 9)

As discussed above, ISMIE (like most insurance companies) purchases reinsurance to cover the risk of excessive judgments, but the ITLA makes this seem like a bargain. Just as in any other form of insurance, reinsurers calculate what premiums they will need to charge to cover what they think their losses will be, plus their other operating expenses; the purpose of the insurance is to spread out the risk of catastrophic loss, not to get something for nothing. The trial lawyers cite a figure of 7.4 percent of premium income as ISMIE's cost of reinsurance, but in fact the number is much higher: in 2008,

ISMIE paid $124.6 million for its reinsurance policies, an amount equivalent to 35 percent of its direct premium income.

"ISMIE representatives admitted under oath that there *was no actual data to support its claim of an increase in frequency of claims*" (p. 6)

There are two basic allegations made in this section: that ISMIE had based its rates on an increase in claims frequency that never happened, and that ISMIE's claims reporting was manipulated in order to create a false lawsuit crisis. Both of these allegations are false.

The basis of the first claim, that ISMIE's rates were not based on actual data, is taken out of context. In 2005, the Insurance Division of the Illinois Department of Financial and Professional Regulation held hearings regarding ISMIE's rates. These hearings were not called for any specific reason; the 2005 medical liability reform law gave the Division of Insurance (DOI) the authority to hold such hearings, so it decided to do so.

At one point, the director of the DOI, Michael McRaith, asked ISMIE executives about claims frequency numbers for the previous rating year. Based on data from the previous several years, ISMIE's actuaries had anticipated a continuation of the rise in claims frequency that had been seen from 1999 to 2003. When claims frequency numbers did not increase as expected in 2004, Director McRaith asked about the apparent discrepancy.

The answer to the Director's question, of course, was that the actuaries had made reasonable assumptions based on the data that were available at the time, and in light of these data they could not have anticipated that claims numbers would fall. The trial lawyers took this answer and twisted it, making it seem as if ISMIE had ignored facts and concealed the truth. None of this is true.

What is true is that after two days of hearings with ISMIE executives, *the Department of Insurance certified ISMIE's 2005 rates as reasonable.* The DOI requested that in 2006, ISMIE should reduce rates by 3.5 percent *if such a reduction was actuarially justified.* As it turned out, ISMIE's actuaries determined that a rate reduction of 5.2 percent was appropriate, so *ISMIE ended up reducing its rates more than the DOI asked.*

The second claim the ITLA makes in this section relates to another question asked by Director McRaith, about ISMIE's reporting of claims. The answer to this question is much more complicated, and as we will explain, it is entirely understandable that the ISMIE executives present at the hearing

did not immediately know how to address the Director's concern. Nevertheless, the answer is quite reasonable, and the ISMIE executives later sent a letter to Director McRaith explaining the discrepancy. Once again, however, the trial lawyers' portrayal of the circumstances is incorrect.

Since it was founded, ISMIE has submitted its annual report to the DOI as required by law. Such standardized annual reports, as we have explained above, are the authoritative source of data for every insurance company. In the early 1980s, however, the DOI began requesting a separate, more specific report that included claims data for individual physicians only (i.e. excluding policies covering physician corporations). To this day, ISMIE executives do not know why the DOI requested this report and the report was never consulted as part of ISMIE'S rate-making process. Nevertheless, in order to comply with the request, ISMIE created a computer program to generate and submit this report to the DOI automatically.

When this computer program was written, ISMIE tracked its policyholders by means of a numbering system. Each policyholder has a number, and the numbers are organized according to what type of policyholder (e.g. individual physician, medical corporation) they are assigned to. In the beginning, this was simple; individual physicians' numbers all had "1" as their first digit, and corporate policy numbers started with a "2." The computer program generating the specific report that was submitted to DOI followed this numbering system.

Some years later, ISMIE began writing clinic policies, and it was found to be more convenient to assign numbers to physicians belonging to clinics that were similar to the numbers assigned to their clinics. The computer program that generated the specific report for DOI was not updated, however. As the number of insured physicians who belonged to clinics increased, the number of physician claims excluded from this report increased as well. The error was not noticed because ISMIE never received any feedback from the DOI about this report, and never used it for any purpose internally.

The reason for the large increase in claims against physicians that was observed in this specific report between 2002 and 2003 was that ISMIE replaced its computer system in 2002, and the program that generated this report was re-written – this time including clinic physicians. When Director McRaith asked about this report, ISMIE executives were confused for the same reason the error had never been caught.

Once again, in summary, the report to which Director McRaith (and the ITLA) referred *was never used for any purpose* within ISMIE. ISMIE's rates *were always determined on the basis of the correct actuarial data found in its annual statements*, and as far as ISMIE is aware this error never had any impact outside the DOI hearing where it was brought up.

"ISMIE employed other deceptive claim-counting practices to concoct the myth of a 'crisis'" (p. 7)

These so-called "deceptive claim-counting practices" that the trial lawyers refer to are two in number: first, the practice of counting multiple individual policyholders who are defendants in a single lawsuit as multiple claims, and second, the reporting as "claims" of deposition assists, records subpoenas and other circumstances that are assigned tracking numbers. In fact, both of these practices are standard and essential to sound insurance operations.

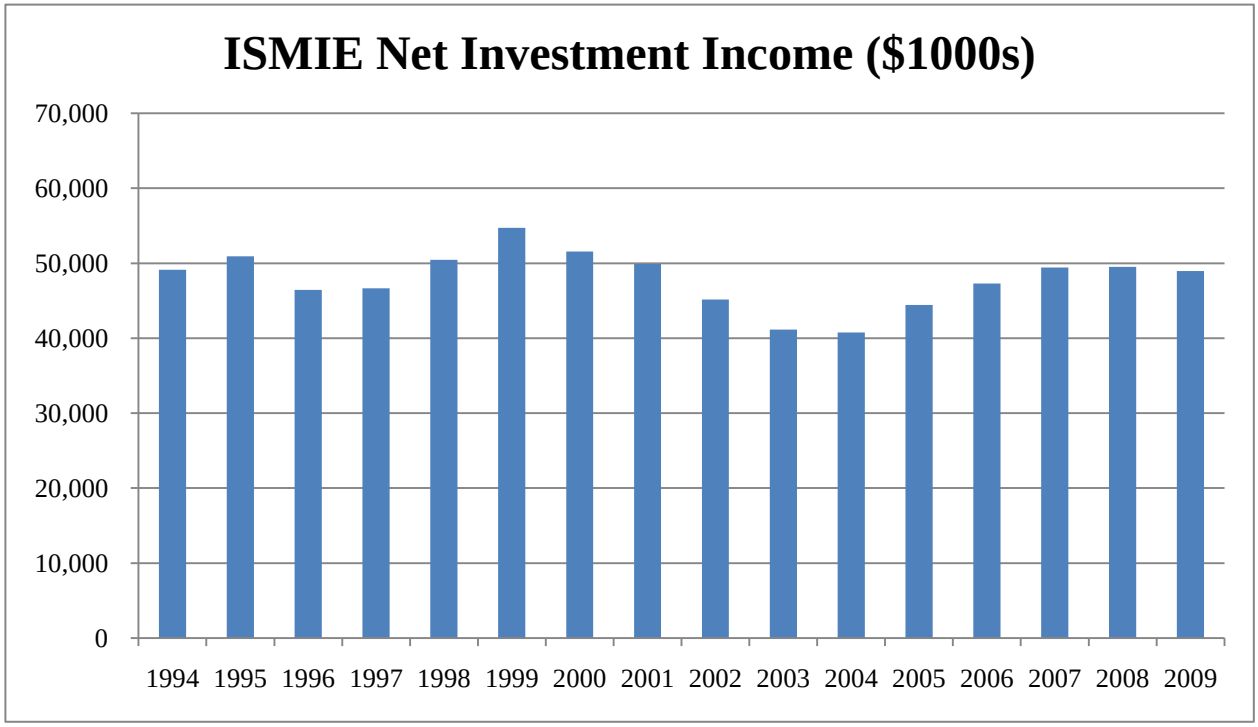
Each policyholder has a separate policy limit, the amount up to which the insurance company will cover a monetary loss. When multiple physicians are named in a single lawsuit, each physician is entitled to separate protection up to his or her policy limit and any judgment against any one physician is a separate claim. Using ITLA's example of a lawsuit naming five physicians as defendants, if judgments are entered against all five physicians, all five claims are closed with indemnity; if a judgment is entered against only one physician, that claim is closed with indemnity and the other four claims are closed without payment to the plaintiff.

The practice of counting multiple individual policyholders who are named in a single suit as multiple claims is not only perfectly legitimate and universally practiced in the insurance industry; it is actually *mandated by the Department of Insurance*. The Department of Insurance issued an order to ISMIE following the 2005 rate hearings that specifies this: "claims shall be reported on a per-defendant basis."

The second allegation made by the trial lawyers in this section is misleading. As we discussed above, ISMIE is careful to distinguish between circumstances where tracking numbers were assigned for convenience and actual claims. ISMIE has never represented to DOI that these deposition assists, records subpoenas or other circumstances were claims and it has never used these numbers as if they were claims. Once again, ISMIE only uses actual claims for rate-setting purposes and for reporting to the DOI in ISMIE's annual statement.

"Another major factor behind the rate increases was that ISMIE was 'not getting the investment yield that it might have received at one time . . . .'" (p. 16)

The trial lawyers seem to be implying here that ISMIE was losing money on its investments in the years leading up to the passage of the 2005 reform law. In fact, because of its conservative investment strategy, ISMIE has consistently experienced positive net income from its investments:



As this chart shows, even when ISMIE's investment income decreased relative to the performance experienced in prior years, it was still very much in positive territory. Even in 2002, when ISMIE experienced a net loss of $61 million, its investment income was not the cause of the problem – large payments on malpractice claims were.

"…the Department of Insurance ordered ISMIE to reduce its insurance rates, [and] create a dividend distribution process to give refunds to policyholders…" (p. 22)

The first of these statements is false, and the second is misleading. As discussed above, the DOI certified ISMIE's 2005 rates as reasonable. It also ordered ISMIE to *target* a 3.5 percent reduction in rates, but *only if that reduction was actuarially justified.* Again, ISMIE reduced its rates *more than the DOI requested* – by 5.2 percent.

As for the second claim, the DOI did indeed order ISMIE to create a process for distributing dividends to policyholders. However, *the DOI left it up to ISMIE to decide based on its financial situation whether, and in what amount, it should actually distribute dividends*. Once again, ISMIE went above and beyond the DOI's recommendation, distributing $37 million to date to its policyholders under the dividend program. In reality, such a dividend program was already well under development at ISMIE Mutual and the insurer welcomed DOI's affirmation of this plan.

"ISMIE has a reputation for stifling competition" (p. 18)

ISMIE exists for the benefit of its policyholders, and anti-competitive behavior would not benefit ISMIE policyholders. ITLA cites as evidence of ISMIE's anti-competitive behavior the fact that ISMIE does not share its internal actuarial data with other companies. This is not true; ISMIE files its actuarial data, on which rates are based, with the DOI, and its competitors have been using that data for years.

In addition, if ISMIE wanted to capture the Illinois market all for itself, it would simply under-price its product. In reality, ISMIE's rates are not the lowest in Illinois. ISMIE prices its product conservatively, because its mission is to be here, over the long term, for its physician policyholders. The survival and stability of the company are of primary importance; market share is not.

"The Physician 'Exodus' is a Myth and Cannot Justify Caps" (p. 25)

In addition to all the misinformation targeted at ISMIE Mutual itself, ITLA denies that physicians were leaving Illinois in response to the medical liability crisis. It is disappointing to find in the ITLA's white paper the statement that "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" (p. 2). Once again, the trial lawyers are counting on casual readers not to dig deeper into any of their claims. It has been pointed out many times over the past several years that this tired old claim in particular is a gross oversimplification that does not reflect the reality of medical care in Illinois.

Tracking the number of physicians in Illinois is an inexact science for a number of reasons. Many physicians maintain their licenses even after they retire because a license is needed to provide volunteer medical services. Many physicians who live in other states maintain Illinois licenses even though they don't practice here; they may have family ties in the area, for example, or they may simply have trained here and moved elsewhere. In addition, physicians who leave Illinois have no obligation to terminate their Illinois licenses even if they do not intend to maintain them, so it can take up to three years to confirm that a departed physician is no longer in the state.

There are other variables that reduce the accuracy of the available statistics regarding the number of doctors practicing in Illinois. The data the trial lawyers cite come from AMA statistics via a report by Neil Vidmar to the Illinois State Bar Association. This report explains and makes use of the AMA's designation of "patient care physicians." The trial lawyers' white paper repeats it without explanation, implying that the term "patient care physicians" refers to physicians who are currently treating patients in Illinois. This is not the case. In fact, the AMA uses this designation simply to exclude doctors employed by the federal government, insurance carriers or pharmaceutical companies. Within this category some physicians have designated themselves "inactive," but there is no way to know the degree to which the remaining physicians are actually seeing patients.

Perhaps more importantly, Vidmar's report acknowledges that even those physicians who do see patients often restrict their practices to part-time hours and low-risk procedures in response to the liability crisis – a fact that the trial lawyers' white paper conveniently ignores. Many Illinois OB/GYNs, for example, reported in a 2008 survey that they had limited the number of high-risk patients they saw and the number of higher-risk procedures they performed in 2004. Significantly fewer OB/GYNs limited their practices in these ways in 2008, and of those that did, significantly fewer did so specifically in response to professional liability concerns than in 2004. While the number of "patient care" OB/GYNs remained relatively steady throughout this time (according to Vidmar's report), this survey shows that fewer of them were offering a full range of services to a full range of patients. This represents a significant reduction in the availability of medical care; the fact that this reduction is not reflected in the statistics cited by the trial lawyers in no way lessens its negative impact on the people of Illinois.

"Medical Malpractice Claims Have Little to No Effect on the Cost of Health Care" (p. 31)

Here, as usual, "The Whole Truth" tells only part of the story – the part that benefits lawyers' flawed case for the status quo. The following are two examples of independent sources that directly contradict ITLA's statement.

ITLA's review of a 2008 Congressional Budget Office study on a common package of medical litigation reform characterized the savings on health care spending as a "relatively small" 0.5 percent. However, ITLA completely ignored the CBO's update of the data. Released in late 2009, new CBO savings estimates increased the earlier assessment tenfold – to as much as $54 billion over the next decade. "CBO currently estimates that the nation's direct costs for medical malpractice – which consist of malpractice insurance premiums and settlements, awards, and legal and administrative costs not covered by insurance – would be reduced by about 10 percent (relative to the amounts under current law) if the common package of tort reforms was implemented nationwide," CBO said. The October 2009 study reported that implementation of tort reform would decrease health care spending by $41 billion and increase federal revenues by approximately $13 billion over 10 years.

Another independent analysis released in February 2010 by the global consulting and actuarial firm Milliman Inc. predicted that physician liability claim costs will increase by 18 percent in Illinois as a result of the Illinois Supreme Court's action overturning reform. "Indemnity claim severities will increase by approximately 23 percent and the average cost that insurers expend defending claims will increase by 10 percent, relative to what these costs would have been, had the cap held. The average overall increase in claims severity will be approximately 18 percent," Milliman reported.

Together these two studies alone cite billions in cost savings attributable to tort reform, nationally and in Illinois – all costs ultimately paid by patients in the form of higher health care bills. "Little to no effect" on the cost of health care …? We beg to differ with ITLA.

"Insurance reforms, not caps, will deal with excessive insurance rates" (Introduction)

Adding onerous insurance regulation to attract or keep insurers in Illinois doesn't make sense. The trial lawyers are looking for a scapegoat, someone who can be blamed for the high costs of their predatory lawsuits.

The centerpiece of the 2005 lawsuit reform law was the cap on non-economic damages. However, there were several other meaningful provisions that helped to improve Illinois' medical liability climate and lower the number of claims clogging our courts. The insurance regulation component was not one of the "difference makers" that have begun to repair our medical liability crisis. Since 2005, claims against ISMIE Mutual policyholders are down by almost 30%. This drop has served as the primary factor allowing ISMIE Mutual to distribute more than $37 million in dividends to policyholders.

The reform law established higher standards for medical experts and transparency during the affidavit of merit process. An affidavit of merit is required in order to file a lawsuit, and the name of the physician who "validates" a claim was previously unknown. Under the old rules, no one could question this unidentified physician's expertise when validating a claim. Simple changes like these represent strong deterrence of non-meritorious claims, which leads to premium stability.

To suggest that insurance regulation is the most meaningful component of the comprehensive reform law either betrays a lack of understanding of the medical liability crisis or reflects a deliberate attempt to draw attention away from the real problems that inhibit patient access to care.

"Medical Malpractice is One of the Leading Causes of Death and Injury – Improved Patient Safety Prevents Malpractice Claims" (p. 33)

This statement is an example of a morsel of truth wrapped in a much larger misdirection. Many casual readers would not be able to spot the inconsistency in the following passage from the ITLA's paper:

> "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.'" (p. 34)

Thompson's statement agrees with the Institute of Medicine's report in using the term "medical errors," but the trial lawyers employ a bait-and-switch tactic, citing the same numbers but using the term "medical malpractice." To a layperson this may seem like a distinction without a difference, but there is a significant difference, and the IOM report itself illustrates it.

The term "malpractice" implies that some individual or group of individuals acted negligently under the circumstances. The IOM report points out that most preventable medical errors do not involve malpractice. Far more commonly, the systems, processes and protocols within which medical professionals work are at the root of the problem. A brief issued by the IOM summarizing the report puts it well:

> One of the report's main conclusions is that the majority of medical errors do not result from individual recklessness or the actions of a particular group--this is not a "bad apple" problem. More commonly, errors are caused by faulty systems, processes and conditions that lead people to make mistakes or fail to prevent them. . . . when an error occurs, blaming an individual does little to make the system safer and prevent someone else from committing the same error. (p. 2)

The processes involved with delivering health care are extremely complex. Physicians and health care providers do not hide behind this fact as an excuse, however; we have a long history of striving to improve these systems and bending over backwards to reduce errors. One example of this is the Illinois State Medical Society's support for the National Patient Safety Foundation and the Coalition for Quality and Patient Safety of Chicagoland. Both organizations seek to improve patient safety by reducing the kinds of medical errors described in the IOM report, and ISMS is fully committed to this goal as well.

It is also important to note that this IOM brief acknowledges that our current medical liability system is a hindrance to patient safety because the fear of a devastating lawsuit is "a serious impediment to systematic efforts to uncover and learn from errors" (p.2). Real medical liability reform is an important step toward the patient safety improvements that doctors and patients alike are striving for, and the openness that these reforms can bring will improve the quality of care for everyone.

A Spotlight on ITLA's Sources

Not only are the statistics cited and the claims made by the trial lawyers misleading at best, the sources they use to make these claims are often suspect. In the text of the ITLA's paper, many sources are listed generically as "scholars" when in fact they are current or former plaintiffs' attorneys, law school faculty or otherwise connected to the trial lawyers' interests. Additionally, in the lengthy list of footnotes attached to the ITLA's paper, many of their sources' credentials are only selectively provided. A few examples of these deceptive tactics are listed below:

- *"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'" (p. 1).*

  The "scholar" quoted here is Edward J. Kionka, a former plaintiff attorney who is now a legal consultant.

- *"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" (p. 6).*

  One of these two researchers is listed as "Lewis L. Laska, Ph.D." Dr. Laska does indeed have a Ph.D., but as long as the ITLA was listing his credentials, why would they omit "J.D." from their citation? After all, Dr. Laska is a plaintiff attorney.

- *"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'" (p. 6).*

  This scholar is Geoff Boehm, Senior Attorney at the New York Public Interest Group, a liberal think tank.

- *"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" (p. 17).*

  As the pattern continues to emerge, one might guess the true identities of these scholars as well: both are lawyers, faculty at the University of Texas Law School.

There are numerous other examples to be found throughout the ITLA's paper. Of course, even when the sources themselves are unbiased, the ITLA often introduces its own bias by only telling part of the story:

- The ITLA quotes Dr. Martin D. Weiss, saying that *"'[t]here are other, far more important factors driving the rise in med mal premiums than caps or med mal payouts'" (p. 20).*

  Another quote from the same article, however, demonstrates a more balanced perspective: "In short, it's clear that caps do accomplish their intended purpose of lowering the average amount insurance companies must pay out to satisfy med mal claims" (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," 7).

- *"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" (p. 27).*

  This study also found that "states with caps on noneconomic damages experienced about 12 percent more physicians per capita than states without such a cap. Moreover, we found that States with relatively high caps were less likely to experience an increase in physician supply than States with lower caps" (Fred J. Hellinger & William E. Encinosa, *The Impact of State Laws Limiting Malpractice Awards on the Geographic Distribution of Physicians* Abstract). Not only do this study's conclusions support the idea that malpractice caps result in greater numbers of physicians per capita, the authors wrote another report in 2006, "The Impact of State Laws Limiting Malpractice Damage Awards on Health Care Expenditures," which concluded that "laws limiting malpractice payments lower state health care expenditures by between 3% and 4%" (*American Journal of Public Health* Vol. 96, No. 8, 1375).

It is easy to see even from these few examples that the trial lawyers are happy to set aside straightforward communication in favor of cherry-picked statistics and misinformation. Illinois physicians will not let these maneuvers hinder the cause of sensible medical liability reforms that will increase access to medical care for the people of Illinois.

Conclusion

In spite of what the Illinois Trial Lawyers Association would have people think, there is a real problem with the judicial system in Illinois as it relates to medical malpractice litigation. Lawsuits are still increasing in severity, as they have been for years, and their frequency is very likely to increase as well now that the comprehensive medical liability reforms enacted by the people of Illinois through their elected representatives in 2005 has been struck down by the Illinois Supreme Court. This crisis is just as real now as it was five years ago, ten years ago, and further in the past.

As always, the physicians of Illinois are here to serve our patients, and that means providing information as well as medical care. The information put out by the ITLA on this particular issue is dangerously misleading, and we will continue to fight for the truth by all available means. The Illinois Supreme Court dealt us all a blow when it ruled against Illinois patients in the *Lebron* case, but where there is a will there is a way. We will continue to search for that way and strive to make it a reality – Reality Medicine, indeed – now and into the future. The Illinois State Medical Society and ISMIE Mutual Insurance Company thank you for standing with us.