



## Faulty Studies from Center for Justice & Democracy Are Stunting the Medical-Malpractice Debate

by Ted Frank and Martin F. Grace

*Congress is scheduled to revisit medical-malpractice reform again this May. Americans for Insurance Reform (AIR), however, has announced that the medical liability crisis is “over,” in an attempt to short-circuit the upcoming debate. This announcement is just the latest in a long line of faulty studies from AIR and its affiliate, the Center for Justice & Democracy (CJD), that have, unfortunately, insinuated themselves into and distorted the national debate. To the extent one believes that the prices doctors pay for malpractice insurance present a crisis, the underlying causes of that crisis have not been addressed, even though rates are currently plateauing. While caps reduce insurance costs, medical liability reform will likely require more than caps in the long run, and medical-malpractice insurance rates could be adversely affected by other legal developments in insurance law.*

CJD and its sibling organization Americans for Insurance Reform are anti-liability reform organizations that regularly issue manifestos masquerading as studies that blame insurers for the medical-malpractice crisis. Their accusations are frequently picked up by newswires, but months later someone looks at the actual study and finds that CJD cherry-picked or otherwise manipulated data to reach invalid conclusions. The refutations, however, never get the play of the original claims. As the Senate takes up medical-malpractice reform again in May, what is certain is that reform opponents will use CJD's misleading arguments in talking points. For example, the Association of Trial Lawyers of America highlighted a CJD study in an April 13 press release attacking President George W. Bush's call for malpractice reform.<sup>1</sup> The House

Judiciary Committee Democratic staff's July 25, 2005, report attacking a malpractice bill passed by the House<sup>2</sup> relied heavily on CJD studies.<sup>3</sup>

CJD is hardly alone in slanting data. Too many organizations supporting malpractice reform exaggerate the growth of a very real problem by using nominal, rather than inflation-adjusted, data.<sup>4</sup> But the difference is one of degree. Even using constant dollars, medical-malpractice claims have grown approximately ten-fold over the last thirty years—with malpractice premiums tripling—and have potential adverse effects on access to care for the specialties worst affected.<sup>5</sup> However, the CJD studies positively misrepresent the state of the world. The result is that major media outlets such as the *New York Times* are questioning the uncontroversial proposition that damages caps reduce insurance costs<sup>6</sup> instead of focusing on legitimate questions: what can we do to create clear-cut standards for medicine to reduce error, and what can we do to make the litigation system less burdensome for good doctors?

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CJD's underlying theses—that malpractice insurance costs are rising because insurance companies are gouging their customers and that caps do not affect insurance prices—contradict basic economic principles. If there are excess profits being made by insurers, one would expect new entrants to rush in to take advantage of the opportunity and eventually compete away the surplus. In fact, we see the opposite: major insurers are deciding that they cannot make money offering medical-malpractice insurance and are leaving the market. In her 2002 testimony to Congress, CJD's Joanne Doroshow claimed that it was relevant that St. Paul Insurance left the medical-malpractice market around the same time it lost money investing in Enron.<sup>7</sup> This seems, at best, a non sequitur. Enron investment losses, even if significant, would not have caused St. Paul to abandon a moneymaking line of business. Furthermore, because of this significant market exit by a commercial insurer (as well as others that have taken place over the last thirty years), an even larger number of doctors obtain their malpractice insurance from physician-owned and operated nonprofit mutual insurance companies. We are being asked to believe that the doctors are overcharging themselves.

Similarly, if it were true that caps had no effect on insurance prices, insurers in states with caps would be missing a great market opportunity, as they could offer identically priced insurance and agree to waive caps. To the extent that patients prefer the opportunity to have unlimited damages when they sue their doctors, such cap-free insurance would quickly drive from the market any recalcitrant insurers that insisted on caps.<sup>8</sup> Even if one believed that existing insurers were too ossified in their beliefs to innovate in such a way, nothing prohibits the trial lawyers of America from pooling their billions in tobacco fees to form a new insurer to take advantage of this opportunity. (Recall that CJD is telling us that the insurer can make tremendous profits from doing so.) If CJD believes its own claims, it is making a serious judgment error in lobbying against insurance companies instead of raising money in the capital markets to compete against and replace them. Not only would the alleged gigantic insurer profits be siphoned from insurers to the new entity, but the new entity's very success would also be dispositive evidence against the efficacy of or need for liability reform.<sup>9</sup>

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So, right off the bat, something is fishy about CJD's conclusions. And sure enough, in recent years, time after time, CJD and its affiliate have had to cherry-pick doctor data and claims to reach those conclusions.

### Once Is Happenstance: "Stable Losses"

AIR, a project of the CJD, released the third edition of its annual report, "Stable Losses/Unstable Rates 2004," in October of that year. The 2004 report, authored by Robert Hunter, argues that insurance prices are cyclical, and that the cycle exists because insurers took investment income and lowered prices to obtain market share. Then, when investment returns are low, the insurers increase rates and gouge the physicians.<sup>10</sup> This was a modulated version of the 2002 report, which claimed that stock market losses were responsible for the rate increases.<sup>11</sup> Apparently AIR had sufficient shame that it retreated from that claim once it was pointed out that 80 percent of medical-malpractice insurer investments are in bonds.

In an effort to make it appear that rates have declined over time, Hunter divides total insurance premiums by the number of doctors, then argues that the ratio has declined since 1975. In a footnote, he pays lip service to the idea that this ratio includes retired doctors and others who have no need of insurance, and waves it away by asserting that the percentage will stay the same over time.<sup>12</sup> But in an age of both increasing lifespans and early retirements, that is clearly not true. For example, the Bureau of Labor Statistics estimates that the number of working surgeons increased 6.5 percent between 1999 and 2002, while Hunter's number is a 9.7 percent increase in nonfederal doctors. Multiply this sort of dampening factor over the nearly thirty years of the study, and its figures will be off by more than a third.

Moreover, one cannot really look at premiums per physician as a meaningful figure. Not all doctors are in the same risk class. General practitioners, obstetricians, and neurosurgeons have distinct risks and distinct malpractice costs and cannot be so easily pooled.

Unfortunately for Hunter, his results are mystifying. His study inflated the denominator so much that it implausibly showed 2003 rates to be lower than the 1975–2003 average, implying that insurers should be raising rates even more.<sup>13</sup> Further, Hunter could not

massage the numbers enough to hide the increase in medical-malpractice losses. Even after using a medical-care inflation figure instead of the base consumer price index (which is arguably more appropriate, since medical-malpractice damages are not just related to medical expenditures) and using the wrong doctor-count denominator to dilute the results, Hunter's study still found that real losses per doctor had more than doubled between 1975 and 2003.<sup>14</sup> Further, the only reason the figure was that low was because the ratio for 1975 was unusually high and that for 2003 unusually low compared to the surrounding years. For example, the increase between 1976 and 2002 was 157 percent, thus showing how sensitive starting and ending dates were in this case.

There is some argument that investments have a minor impact on insurance rates: a study by the Government Accountability Office (GAO) concluded that a 1 percentage point increase in insurers' investment-return rates translates into the ability to lower premiums about 4.5 percentage points.<sup>15</sup> But medical-malpractice insurers' investments have been conservative (5.6 percent rate in 2000, 4 percent in 2002); the GAO translates this into a 7.2 percent difference in premiums, not the double- and triple-digit increases seen over the last few years. In the long run, medical-malpractice insurance prices reflect the costs of providing medical-malpractice insurance—and those, as the GAO found, have been steadily rising.

## Twice Is Coincidence: The Angoff Report

There was no "Stable Rates/Unstable Losses 2005." Either the 2004 numbers ceased to support the methodology or CJD decided it needed a new methodology to grab press attention. If the latter, the ploy worked. In July 2005, CJD commissioned and released a report by Jay Angoff entitled, "Falling Claims and Rising Premiums in the Medical Malpractice Insurance Industry." The report's conclusion that "doctors have been price-gouged for several years as insurance industry profits have ballooned to unprecedented levels," received national publicity.<sup>16</sup>

This study, too, had to slice its data to reach these results.<sup>17</sup> First, it excluded from its research companies that had exited the market, such as St. Paul, PHICO, and Farmers Insurance. But malpractice insurers insure on a "claims-occurred" basis: if an event occurred some years in the past but is only recently discovered, the

insurer covering the provider when the claim physically occurred is liable for the coverage. Thus, these companies that have exited the medical-liability business continue to incur billions of dollars of underwriting losses (unsupported by any additional premiums) even today, years after they have left the market. Add back into Angoff's study the omitted billion dollars or so these exiting companies had collected by 2001, as well as their underwriting losses, and CJD's conclusions of rapid premium increase and falling claims dissipate.

What is truly amazing about the report, however, is its absolute failure to consider expenses. Angoff looks only at claims paid and not the other expenses incurred in defending those claims. But defense lawyers are not free. If we include loss adjustment expenses (the expenses insurers pay to litigate and settle claims), we see that while the loss ratio including the expenses has decreased since 2000, it is still greater than one. Thus, on average, it costs \$1.09 to close a case for each dollar of premium paid. This does not sound like the insurance industry is "profiteering," as Connecticut attorney general Richard Blumenthal accused in a CJD press release.<sup>18</sup> To be fair, this apparent loss turns into a profit when one includes investment returns; but still, the profit for 2004 was the first one in years. One year of profitability is hardly profiteering, but is rather a sign of health that will signal others to enter the industry, as is already happening in Texas after it enacted numerous tort reforms.<sup>19</sup>

Moreover, Angoff started his study in 2000, thus omitting the tremendous rise in the loss ratio that occurred in the 1990s. By expanding the scope of the Angoff inquiry in three dimensions—from a few years to the last fifteen, from fifteen surviving insurers to the entire industry, and from a subset of costs to the combined ratio of all costs and expenses to premiums—we get a different, and much more accurate, picture.

Medical-malpractice expenses rose sufficiently high that it took the giant premium increases of the early part of this decade to return the combined ratio to 1997 levels. And because these numbers exclude investment returns, one cannot blame Enron for the fluctuations.

The Angoff study examines insurer profitability, further slicing the data and cutting off the inquiry into surpluses and stock prices at 2002. Once again, as Jim Copland found, merely extending the scope of the study a few years dramatically changes the picture as the rise in stock prices between 2002 and 2005 only partially compensates for a tremendous drop between 1999 and

TABLE I  
MEDICAL MALPRACTICE COMBINED RATIO

Year	Percent
1990	106
1991	104
1992	128
1993	108
1994	96
1995	100
1996	107
1997	108
1998	116
1999	130
2000	134
2001	154
2002	141
2003	139
2004	109

SOURCES: AM Best Aggregates & Averages, 1990–2002; Insurance Information Institute, 2003–2004.

2002. A \$3.4-billion industry-wide surplus in 2002 was down 15 percent from 1999.

Angoff's report also implies a sinister motive to the increase in surplus to the medical-malpractice carriers, as Angoff claims that each of the companies he looks at has capital that "exceeds the surplus the NAIC [National Association of Insurance Commissioners] deems as adequate."<sup>20</sup> The NAIC and the states have a risk-based capital (RBC) standard that requires the company to hold assets in reserve in accordance with the risk the companies face. Thus, companies writing riskier lines of business must hold more capital to ensure solvency. The NAIC designed RBC, in part, to focus regulators on the truly troubled companies and provide the regulators with authority to undertake specific remediation if the insurer's capital falls to such a level as to threaten the insurer's viability. RBC is a floor, not a ceiling; it was never suggested as an ideal or maximum amount of capital for an insurer to hold. When scrutinized, Angoff's accusation dissolves into a neutral factual statement that insurers (after substantial and necessary rate increases caused by increased loss ratios) have escaped insolvency. What is truly fascinating about Angoff's position is that he was the former insurance commissioner for the state of Missouri and would likely be extremely concerned if any or all the companies under his jurisdiction had only the

minimum level of surplus required by the risk-based capital requirements. In fact, prudent managers will always attempt to have a number greater than the minimum. Therefore, Angoff's accusation is disingenuous at best.

The CJD report made the front page of the *New York Times* business section.<sup>21</sup> When the American Academy of Actuaries took the highly unusual step in October 2005 of criticizing the Angoff report as "incomplete, actuarially unsound, and misleading," the *Times* ignored the refutation.<sup>22</sup>

### Three Times Is Enemy Action: The February 2006 AIR Report

CJD's Joanne Doroshow teamed with Robert J. Hunter to write "Insurance 'Crisis' Officially Over" in February 2006.<sup>23</sup> AIR calculated that medical-malpractice rates did not average any increase in 2004. (Never mind the 17 percent decrease in malpractice rates in Texas having something to do with that average rate. It is also worth noting that, without explanation for the difference, AIR changed its methodology for computing insurance rate increases since its 2004 report, suggesting cherry-picking.)

Amazingly, AIR concluded that a lack of increase or decrease proved that there was no longer any concern or crisis. Of course, if a doctor suggested to a patient who had doubled his cholesterol levels between 2000 and 2003 that the lack of movement in 2004 meant he was no longer at cardiovascular risk, he might be sued for malpractice. Readers can surely think of other examples. Imagine a hapless politician who suggests that unemployment is no longer a problem because, after years of increases, it has plateaued at 12 percent.

Worse, AIR got caught playing fast and loose with the data the same day they released the report. They claimed the Council of Insurance Agents & Brokers (CIAB) as a source, and CIAB acidly pointed out that AIR's claim of a 63 percent increase in fourth quarter 2002 rates actually came from a study showing that 63 percent of insurance accounts renewed that quarter had increased rates.<sup>24</sup>

Even beyond these painfully silly flaws, the report purported to show that caps had no effect on rate increases—with anecdotal evidence from a handful of states. Of course, looking at about five states with caps and about five states without caps is not a study. Ten data points make it nearly impossible to get statistical validation, and none is attempted. What is important is the relative size of the premium, the health of the market, and

whether other liability reforms are in place—not just whether the states had premium increases.

CIAB’s rapid response perhaps deterred the mainstream media from acting as AIR’s press agent for this study, as they had for the 2005 CJD study. Even the Association of Trial Lawyers of America appears to have been sufficiently ashamed that it ignored the paper on the front page of its website. But the fact that the *Washington Monthly’s* “Political Animal” blog was quick to trumpet (and never retracted) the bogus numbers makes one worry that such false statistics will find their way into the legislative debate.<sup>25</sup>

As always, AIR takes the position that liability crisis is never caused by litigation, expansive judicial interpretation, or bad science. Instead, AIR would have us believe it is caused by mismanagement or greed by insurers. Or, as AIR alleges in this paper, it was caused by insurers that lowered premiums too much last decade because of mismanagement and now have to raise them. (Somehow, it is hard to imagine that Doroshov and Hunter would have contemporaneously applauded insurers that raised prices in the 1990s for their fiscal responsibility.)

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problems of liability markets are only temporarily masked by the post-shock recovery. Abraham listed the reasons why a future crisis was inevitable in 1991; many of these reasons still apply today.

First, there is “tort cost push” because of increased frequency and severity of losses and increases in the largest, outlier awards. During the last crisis we saw a number of indicators of increased frequency and severity.<sup>28</sup> Anecdotally, we also saw a number of cases involving cerebral palsy due to alleged OB/GYN delivery room errors. And anecdotal evidence is relevant to these inquiries: it takes only a few outlier cases in a few states to raise OB premiums nationwide. Geoffrey Fieger has a multistate practice, and when he won a \$17.5-million verdict in Pennsylvania in 2000, it was a data point that insurers in other states had to consider. Just the possibility that such a result could be replicated in another state is enough to increase the risk to an insurer of a lawsuit and raise premiums, even if there is no history of such a case happening in a particular state. This is more than just hypothetical. Fieger went on to win, among other cases against obstetricians and their hos-

pitals, a \$30-million verdict in Ohio and, just this March, a \$17-million verdict in West Virginia. West Virginia has a non economic damages cap, but the end result in the Pochron family’s lawsuit against obstetrician Louise E. Van Riper is to reduce the award to \$13 million—prime demonstration that caps are only part of a reform effort and cannot carry the liability reform burden by themselves.<sup>29</sup>

Of course, if there were a true relationship between cerebral palsy and delivery methods, physicians could learn safer techniques to deliver babies. Malpractice costs and birth defects would decrease and everyone would be better off. However, caesarian sections have quintupled without any decrease in cerebral palsy incidence.<sup>30</sup> All that is being added is costs to the system.

Second, there is increased legal uncertainty in the market. Legal uncertainty influences state markets in more ways than just higher or lower insurance prices. A major rationale behind liability reform is to reduce legal uncertainty. If one looks at common reform proposals such as damage caps, venue limitations, firm statutes of limitation, ending joint and several liability, or even restrictions on expert testimony, they tend to focus on reducing uncertainty. If we think about insurance pricing,

### “The Once and Future Crisis”

But now, according to AIR, the malpractice crisis will be over when the cycle is stabilized, arguing that the cycle is not caused by lawsuits, but by some external insurance market peculiarity. Therefore, AIR asks us to conclude that liability reform was a waste, as the insurance market will come back by itself. Again, this argument avoids the litigation and judicial-behavior side of the equation. It also avoids the state of the state malpractice insurance markets.

The problem with AIR’s hypothesis is that an insurance cycle is not really a cycle at all, but rather a reaction to unpredictable shocks.<sup>26</sup> While we have had three shocks that correspond to the malpractice crises of the past, the industry has returned to some level of “profitability and stability” after the effects of the shock have worn off. The question that needs to be addressed is whether this a fragile stability or something more permanent.

University of Virginia Law professor Kenneth Abraham perhaps gives us the answer with a prescient 1991 paper titled, “The Once and Future Crisis.”<sup>27</sup> Abraham predicted the current decade’s crisis because the underlying

price is equal to the expected losses and expenses plus the cost of risk. We know that as the expected losses increase, the premiums go up, but as the cost of risk increases, premiums go up, too. Studies to date—even the more sophisticated academic ones that go beyond the single-variable models of CJD—simply have not addressed the importance of variance and extraterritorial effects.

Finally, Abraham discusses the potential problem caused by expansive judicial interpretations of insurance policies. Individuals only tangentially related to a risk may be responsible for the entire risk. Some of the liability reforms recently enacted go after this problem by reducing the effect of joint and several liability. But this particular problem does not necessarily have to be related directly to medical malpractice. For example, suppose judges in the Gulf states raked by Hurricane Katrina follow the demands of Mississippi attorney general Jim Hood and decide that homeowners’ insurers are responsible for a specifically excluded loss, such as water damage. This decision will have an effect on homeowners’ markets nationwide. But it will also affect all lines of insurance: insurers will perceive insurance contracts to have an increased risk of ex post judicial revision. Reinsurers will perceive this as a risk and therefore increase prices to compensate. Reinsurance costs will rise for all insurers no matter the line of business.

CJD and AIR believe that malpractice insurers are price gougers and deserve to lose money. However, consumer advocates did not complain when prices were being lowered, as they were in the mid-1990s. AIR forgets that insurance is a voluntary business based on risk assessment. It seems to believe that all regulators have to do is wave a magic wand and prices will become reasonable. Increased regulation, however, is not the answer. Stockholders require compensation for risk-taking, or they will not take the risk. However, insurers’ prices are constrained by competition with the mutuals and risk retention groups, which act like nonprofits. In turn, it is hard to envision the managers of a nonprofit trying to raise insurance prices just so they can give back bigger dividends to their physician-owners. The nonprofits’ motive is to make sure that they charge sufficient premiums to stay solvent rather than to extort premiums from their policyholders.

Liability reform has attempted to reduce uncertainty through limitations on losses or legal standards. One will not be able to determine until the next shock occurs how well the medical-malpractice insurance market has fared. But given the evidence from the past, one cannot conclude the crisis is over and that the markets are stable, much less that liability reform was or will be a waste.

We have new empirical evidence that doctors leave and enter markets in response to economic incentives.<sup>31</sup> Future studies may confirm or reject this common-sense hypothesis, but it is beyond question that insurers will actually leave markets when driven out by “consumer advocates” who only advocate for trial lawyers.

There is a legitimate debate to be had over the role of the liability system in promoting patient safety and injury compensation, a debate that has the potential to reduce health-care costs, improve health-care access, and ultimately save lives. Unfortunately, the debate is being sidetracked. In many ways, the problem with AIR’s reports is a perfect microcosm of what doctors find most distasteful about the liability system: a trial-lawyer mentality that cherry-picks facts and twists data to reach knee-jerk conclusions under the guise of a false science. But how many times must CJD and AIR demonstrate that they either do not understand or will not apply basic principles of insurance markets and pricing before the media and politicians stop interjecting their seriously flawed conclusions into the discussion?

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*AEI research assistant Philip Wallach and AEI editorial assistant Nicole Passan worked with Mr. Frank and Dr. Grace to edit and produce this Liability Outlook.*

## Notes

1. American Trial Lawyers Association, “ATLA CEO Jon Haber’s Statement in Response to Bush’s Attacks Today on the Civil Justice System,” news release, April 13, 2006, available at [www.atla.org/pressroom/PressReleases/2006/april13.aspx](http://www.atla.org/pressroom/PressReleases/2006/april13.aspx) (accessed April 19, 2006).

2. *Help Efficient, Accessible, Low-cost, Timely Healthcare (HEALTH) Act of 2005*, HR 5, 109th Cong., *Congressional Record*, daily ed. (July 27, 2005): H 6860–69, available at [www.govtrack.us/congress/bill.xpd?bill=h109-5](http://www.govtrack.us/congress/bill.xpd?bill=h109-5) (accessed April 20, 2006).

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3. U.S. House of Representatives, report of the House Judiciary Committee Democratic staff, *H.R. 5, Bad Medicine for American Consumers*, July 25, 2005, available at [www.house.gov/judiciary\\_democrats/medmel109/staffrept72505.pdf](http://www.house.gov/judiciary_democrats/medmel109/staffrept72505.pdf) (accessed April 20, 2006).

4. Bernard Black of the University of Texas made this point at an AEI conference, “Is There a Crisis in Medical Malpractice? New Evidence from Texas” (American Enterprise Institute, Washington, D.C., March 31, 2005), summary available at [www.aei.org/event1037/](http://www.aei.org/event1037/) (accessed April 20, 2006).

5. Joseph B. Treaster and Joel Brinkley, “Behind Those Medical Malpractice Rates,” *New York Times*, February 22, 2005, C2; for evidence of the adverse effects, see Jonathan Klick and Thomas Stratmann, “Medmal Reform and Physicians in High Risk Specialties” (working paper, American Enterprise Institute, Washington, D.C., March 21, 2006), available at [www.aei.org/docLib/20060406\\_KlickMedmalReform.pdf](http://www.aei.org/docLib/20060406_KlickMedmalReform.pdf) (accessed April 20, 2006).

6. Compare Joseph B. Treaster and Joel Brinkley, “Behind Those Medical Malpractice Rates,” with Tom Baker, *The Medical Malpractice Myth* (Chicago, Ill.: University of Chicago Press, 2005), 110–11. Baker, while opposing caps, acknowledges that they reduce insurance costs. For a scientific analysis supporting the general result that insurance costs are lower in states with caps, see also W. Kip Viscusi and Patricia H. Born., “Damages Caps, Insurability, and the Performance of Medical Malpractice Insurance,” *Journal of Risk and Insurance* 72, no. 1 (2005): 23–43, abstract available at <http://ssrn.com/abstract=669216> (accessed April 20, 2006).

7. House Subcommittee on Commercial and Administrative Law, Oversight Hearing on Health Care Litigation Reform, *Does Limitless Litigation Restrict Access to Health Care?* statement of Joanne Doroshow, executive director, Center for Justice & Democracy, June 12, 2002, available at [www.centerjd.org/free/testimony.pdf](http://www.centerjd.org/free/testimony.pdf), 10 (accessed April 20, 2006).

8. Of course, it is far from clear that consumers *do* prefer unlimited liability. When given the opportunity to opt out of noneconomic damages in exchange for lower auto insurance rates that reflect the savings from the option, about 90 percent of New Jersey drivers do so. See Stephanie Owings-Edwards, “Choice Automobile Insurance: The Experience of Kentucky, New Jersey, and Pennsylvania,” *Journal of Insurance Regulation* 23, no. 1 (2004): 25–42.

9. This theme is further developed in Ted Frank, “Malpractice Myths,” *Point of Law* (February 23, 2005), available at [www.pointoflaw.com/columns/archives/000975.php](http://www.pointoflaw.com/columns/archives/000975.php) (accessed April 19, 2006).

10. Americans for Insurance Reform, *Medical Malpractice Insurance: Stable Losses/Unstable Rates 2004* (New York, N.Y.:

Americans for Insurance Reform), October 2004, available at <http://insurance-reform.org/StableLosses04.pdf> (accessed April 20, 2006).

11. Americans for Insurance Reform, *Medical Malpractice Insurance: Stable Losses/Unstable Rates* (New York, N.Y.: Americans for Insurance Reform), October 10, 2002, available at [www.centerjd.org/air/StableLosses.pdf](http://www.centerjd.org/air/StableLosses.pdf), 3 (accessed April 20, 2006).

12. Americans for Insurance Reform, *Medical Malpractice Insurance: Stable Losses/Unstable Rates 2004*, n. 4.

13. *Ibid.*, 5.

14. *Ibid.*, 7.

15. Government Accountability Office, report to Congressional requesters, GAO-03-702, *Medical Malpractice Insurance: Multiple Factors Have Contributed to Increased Rate Premium Rates*, June 2003.

16. Jay Angoff, *Falling Claims and Rising Premiums in the Medical Malpractice Insurance Industry*, Center for Justice and Democracy (New York, N.Y.), July 2005, available at [www.centerjd.org/ANGOFFReport.pdf](http://www.centerjd.org/ANGOFFReport.pdf) (accessed April 20, 2006).

17. Jim Copland made many of these points first in “CJD’s Med Mal Math,” *Point of Law* (July 8, 2005), available at [www.pointoflaw.com/archives/001292.php](http://www.pointoflaw.com/archives/001292.php) (accessed April 19, 2006).

18. Center for Justice & Democracy, “Two Leading State Attorneys General and State Insurance Commissioner Strongly Challenge the Insurance Industry’s Price-Gouging of Doctors—Call for Oversight,” news release, July 7, 2005, available at [www.centerjd.org/press/release/050707.htm](http://www.centerjd.org/press/release/050707.htm) (accessed April 20, 2006).

19. See, for example, Travis E. Poling, “Lawsuit Limit May Be Just What the Doctors Ordered,” *San Antonio Express-News*, February 26, 2006, A1.

20. Jay Angoff, *Falling Claims and Rising Premiums in the Medical Malpractice Insurance Industry*, 23.

21. Jenny Anderson, “Study Says Malpractice Payouts Aren’t Rising,” *New York Times*, July 7, 2005, C1.

22. American Academy of Actuaries, “American Academy of Actuaries’ Medical Malpractice Subcommittee on the report by the Center for Justice & Democracy, *Falling Claims and Rising Premiums in the Medical Malpractice Insurance Industry*,” news release, February 27, 2006, available at [www.actuary.org/pdf/casualty/medmal\\_stmt1005.pdf](http://www.actuary.org/pdf/casualty/medmal_stmt1005.pdf) (accessed April 20, 2006).

23. Joanne Doroshow and Robert J. Hunter, *Insurance “Crisis” Officially Over* (New York, N.Y., Americans for Insurance Reform) February 27, 2006, available at [www.insurance-reform.org/pr/MMSOFTMARKET.pdf](http://www.insurance-reform.org/pr/MMSOFTMARKET.pdf) (accessed April 20, 2006).

24. The Council of Insurance Agents and Brokers, “The Council Challenges AIR Conclusions on Med Mal,” news release, February 27, 2006, available at [www.ciab.com/Template.cfm?Section=News\\_Releases2&CONTENTID=](http://www.ciab.com/Template.cfm?Section=News_Releases2&CONTENTID=)

4998&TEMPLATE=/ContentManagement/ContentDisplay.cfm (accessed April 20, 2006).

25. Kevin Drum, "No More Crisis . . ." Washington Monthly, Political Animal (weblog), February 27, 2006, available at [www.washingtonmonthly.com/archives/individual/2006\\_02/008311.php](http://www.washingtonmonthly.com/archives/individual/2006_02/008311.php) (accessed April 20, 2006).

26. See, for example, Julie Cagle and Scott Harrington, "Insurance Supply with Capacity Constraints and Endogenous Insolvency Risk," *Journal of Risk and Uncertainty* 11, no. 3 (1999): 219–32.

27. Kenneth Abraham, "The Once and Future Crisis," *Journal of Risk and Uncertainty* 4, no. 4 (1991): 353–71.

28. Aon examined its claims and found that severity of medical malpractice claims has been growing at a nominal rate of 7.5 percent over the period 1995–2005, well over the rate of inflation in terms of the consumer price index growth rate (which has averaged approximately 2.8 percent per year, according to the Minneapolis Federal Reserve Bank, <http://minneapolisfed.org/research/data/us/calc/>).

See Aon Corporation, 2005 *Hospital Professional Liability and Physician Liability Benchmark Analysis* (Chicago, Ill.: Aon, 2005).

29. Natalie Neysa Alund, "Jury Awards \$17 Million in Lawsuit against Mon General Hospital: Child Suffered Brain Damage after Emergency Caesarean Section," *Dominion Post* (Morgantown, W.V.), March 29, 2006

30. Steven L. Clark and Gary D. V. Hankins, "Temporal and Demographic Trends in Cerebral Palsy—Fact and Fiction," *American Journal of Obstetrics and Gynecology* 188, no. 3 (2003): 628–33.

31. Jonathan Klick and Thomas Stratmann, "Medmal Reform and Physicians in High Risk Specialties"; Daniel P. Kessler, William M. Sage, and David J. Becker, "The Impact of Malpractice Reforms on the Supply of Physician Services," *Journal of the American Medical Association* 293, no. 21 (2005): 2618–25, abstract available at [www.jama.ama-assn.org/cgi/content/short/293/21/2618](http://www.jama.ama-assn.org/cgi/content/short/293/21/2618) (accessed April 20, 2006).