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The Fleecing of Seriously Injured Medical Malpractice Victims in Illinois

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I. INTRODUCTION

It is fundamental to our system of justice and the primary goal of our tort system that victims of negligent conduct be made whole through the only means possible, monetary compensation.¹ To this end, in medical malpractice cases, just as in any bodily injury related tort case, plaintiffs who establish a defendant's liability are entitled to recover for their medical expenses, care-taking expenses, and loss of income, otherwise known as economic damages.² Equally important, they are entitled to compensation for human loss, the toll their injuries take on the quality of their lives in the form of pain and suffering, disability and disfigurement.³ When the injury results in death, family members are entitled to compensation for the bitterest harm of all: the loss of love and affection.⁴ These are otherwise known as non-economic damages.

The insurance and medical industries have long contended that non-economic damage awards in medical malpractice jury trials, especially pain and suffering, are responsible for the high cost of malpractice insurance for physicians. They make sensational and inflammatory claims wholly unsupported by empirical evidence, often simply citing to anecdotal stories to justify their contentions. In response to these spurious claims, lawmakers in Illinois recently enacted legislation limiting non-economic damages to \$500,000 against a physician and \$1,000,000 against a hospital in medical malpractice cases.⁵

The purpose of this article is to demonstrate that non-economic damage awards are not fueling the rapid rise in malpractice insurance rates, and damage limitations do not reduce malpractice insurance premiums. It will examine the major claims made by the insurance and medical lobbies to

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1. *Best v. Taylor Machine Works*, 689 N.E.2d 1057, 1076 (Ill. 1997).
2. Illinois Pattern Jury Instructions: Civil, Nos. 30.06, 30.07, 30.08 & 30.09 (2005 ed.).
3. Illinois Pattern Jury Instructions: Civil, Nos. 30.04, 30.04.01 & 30.05 (2005 ed.).
4. Illinois Pattern Jury Instructions: Civil, Nos. 31.01 & 31.11 (2005 ed.).
5. 2005 Ill. Legis. Serv. 3440 (West).

manipulate public and legislative support for caps on non-economic damages and show that each is misleading, not supported by empirical data, or simply false. Reprehensibly, cap legislation burdens those in need of the most protection, seriously injured medical malpractice victims, who are victimized again, this time in favor of insurance industry profiteering.

II. BACKGROUND

This most recent effort to limit medical malpractice victims' right to recover damages is not new to Illinois. It has been attempted twice before, and each time, the Illinois Supreme Court has held such legislation to be unconstitutional. The first attempt came in 1975, when the General Assembly passed "an Act to revise the law in relation to medical malpractice."⁶ The Act limited the maximum amount of all damages recoverable by a plaintiff "on account of injuries by reason of medical, hospital or other healing art malpractice" to \$500,000.⁷ But in *Wright v. Central Du Page Hospital Ass'n*, the Illinois Supreme Court found that the limitation on medical malpractice recovery constituted special legislation in violation of the 1970 Illinois Constitution.⁸ The court held that whenever recovery is permitted or denied on an arbitrary basis, a special privilege is granted in violation of the special legislation clause, and that limiting recovery to \$500,000 only in medical malpractice actions is arbitrary.⁹

Two decades later, in 1995, the General Assembly once again tried to restrict victims' rights, passing the Civil Justice Reform Amendments.¹⁰ The most contentious provision was a \$500,000 limitation on non-economic damages in bodily injury cases, death cases and physical damage to property cases based on negligence or product liability.¹¹ In *Best v. Taylor Machine Works*, the court again considered the constitutionality of a damage limitation and again held that the cap violated the special legislation clause.¹² The court stated that "the purpose of the special legislation clause is to prevent arbitrary legislative classifications that discriminate in favor of a select group without a sound, reasonable basis."¹³ A law is violative of the special legislation clause when it contains an arbitrary

6. 1975 Ill. Legis. Serv. 2888 (West).

7. ILL. REV. STAT. ch. 70, § 101 (1975).

8. 347 N.E.2d 736 (Ill. 1976). The special legislation clause states: "The General Assembly shall pass no special or local law when a general law is or can be made applicable. Whether a general law is or can be made applicable shall be a matter for judicial determination." ILL. CONST. art. IV, § 13.

9. *Wright*, 347 N.E.2d at 743.

10. Pub. Act 89-7, 1995 Ill. Laws 284, 299 (repealed 1997).

11. 735 ILL. COMP. STAT. 5/2-1115.1(a) (1995).

12. 689 N.E.2d 1057 (Ill. 1997).

13. *Id.* at 1069-70.

classification of similarly situated individuals without adequate justification or connection to a legitimate state interest.¹⁴

The court held that the statutory cap on compensatory damages for non-economic losses was arbitrary because the statute limited damages only in certain tort cases and undermined the goal of the tort system to make victims whole.¹⁵ Rejecting the defendants' contention that the legitimate state interest was a system wide tort liability cost savings, the court held that even if there were such unspecified savings, the special legislation clause prohibits such savings on the backs of one class of tort victims.¹⁶

The court further found that the legislation was violative of the separation of powers clause, which prohibits any of the three branches of government from "exercis[ing] powers properly belonging to another."¹⁷ The court stated that the authority and obligation to reduce excessive jury verdicts rests with the judiciary through the doctrine of remittitur.¹⁸ Remittitur is a uniquely judicial function that is essential to the administration of justice and should be considered only on a case by case basis.¹⁹ However, the court found that the statutory cap was a "legislative remittitur," which operated without regard to the proven specific non-economic damages of injured plaintiffs.²⁰ As such, this legislative remittitur unduly encroached on the court's fundamental "judicial prerogative of determining whether a jury's assessment of damages is excessive within the meaning of the law," and hence, violated the separation of powers clause.²¹

Despite these clear precedents, on August 25, 2005, Governor Rod Blagojevich capitulated to public pressure manipulated by the powerful insurance and medical industries. He signed into law Public Act 94-677, which, among other things, limits non-economic damages in medical malpractice cases to \$500,000 against physicians and \$1,000,000 against hospitals, even though the data clearly shows that non-economic damage awards are not fueling the increase in physicians' premiums.²²

The medical malpractice insurance industry, through medical trade associations, has waged a public relations campaign to convince the public that there is a medical malpractice crisis, i.e., that too many people are suing doctors and getting too much money for their pain and suffering. They allege that large payouts are causing premiums to rise, forcing doctors

14. *Id.* at 1072.

15. *Id.* at 1076.

16. *Id.* at 1077.

17. ILL. CONST. art. II § 1.

18. *Best*, 689 N.E.2d at 1079.

19. *Id.*

20. *Id.* at 1080.

21. *Id.*

22. Pub. Act 94-677, 2005 Ill. Legis. Serv. (West).

to either leave the state in search of more affordable rates, limit their practices or retire. This resonates with the public, who are fearful of a loss of available medical care. But, on the contrary, both the public and physicians are being duped. The losers are seriously injured medical malpractice victims, who are deprived of a jury's determination of the full measure of their damages, and physicians, whose rates continue to rise despite cap legislation. Meanwhile, insurance companies reap increased profits through windfall legislation that reduces their exposure, while the pain and disability of malpractice victims persists uncapped. The next section discusses the major insurance and medical industries' claims in support of caps on non-economic damages and demonstrates that they are baseless.

III. ONLY A VERY SMALL NUMBER OF THE MANY VICTIMS OF MEDICAL MALPRACTICE SEEK COMPENSATION FOR THEIR INJURIES

The insurance and medical lobbies have created a caricature of the sue-happy, greedy and undeserving patient who enters the medical malpractice lottery hoping to win the jackpot. Tom Baker, author of *The Medical Malpractice Myth*, describes public perception this way: "According to the myth, people sue at the drop of a hat with no good reason, juries regularly hand out huge sums to almost anyone who asks, and, as a result, doctors, hospitals, and insurance companies have to pay large ransoms to escape from the clutches of the tort system even when the doctors did nothing wrong."²³ However, research decisively debunks this myth of the medical malpractice plaintiff.²⁴

In reality, victims of medical malpractice rarely sue healthcare providers. Far more patients are injured each year by medical negligence than those who actually pursue a claim. One study estimated that as many as 98,000 people die in hospitals each year from preventable medical errors in the United States.²⁵ Here in Illinois, there are as many as 4,325 patient deaths per year.²⁶ Not included in these figures are the many people who suffer serious but non-fatal preventable medical injuries. Yet, only an estimated 4% of malpractice victims pursue a claim.²⁷ Thus, up to 96% of medical malpractice victims never seek compensation for their often

23. TOM BAKER, *THE MEDICAL MALPRACTICE MYTH* 68 (2005).

24. *Id.*

25. *Id.* (citing INST. OF MED. OF THE U.S. NAT. ACAD. OF SCI., *TO ERR IS HUMAN* (1999)).

26. PUBLIC CITIZEN'S CONGRESS WATCH, *MEDICAL MISDIAGNOSIS: CHALLENGING THE MALPRACTICE CLAIMS OF THE DOCTOR'S LOBBY*, PUBLIC CITIZEN'S CONGRESS WATCH 13 (2003).

27. BAKER, *supra* note 23, at 69.

debilitating injuries. Furthermore, this number has decreased in Illinois over the past decade.

Dr. Neil Vidmar, a recognized researcher and author on medical malpractice litigation, was recently commissioned by the Illinois State Bar Association to determine whether medical malpractice litigation in Illinois is the cause of medical liability insurance premium increases.²⁸ As part of this study, Dr. Vidmar examined all of the medical malpractice case filings between 1994 and 2004 in the two most populous counties in Illinois, Cook and DuPage.²⁹ Together, these counties comprise 49% of the population of the state and two-thirds of patient care physicians.³⁰ The data he compiled demonstrates a downward trend in medical malpractice case filings during that ten year period.³¹

In Cook County, there were 1,831 filings in 1994, but only 1,226 in 2004.³² From 1996 until 2004, filings remained relatively stable within a range of 1,214 to 1,443.³³ Similarly, in DuPage County, there were 113 filings in 1994, but only 57 in 2004.³⁴ From 1996 until 2004, filings remained within a range of 57 to 80.³⁵ Ironically, just a year before dramatically raising its premiums, ISMIE Mutual Insurance Company, Illinois' largest medical malpractice insurer, acknowledged this downward trend, reporting that "[d]ue to the favorable trends in claims reported since mid-1995, we have recently modified our reinsurance strategy to increase our retention and decrease premiums and risk ceded to reinsurers."³⁶

Not only has there been a reduction in the number of medical malpractice suits filed over the past ten years, but the number of indemnity payments made annually by ISMIE statewide has decreased in recent years. ISMIE paid 400 claims in 1998, compared with 281 claims in 2004, with a nominal increase in 2004 over 2003.³⁷ Intuitively, it would seem that the number of suits filed and claims paid should rise steadily from year to year

28. NEIL VIDMAR, ILL. STATE BAR ASS'N, *MEDICAL MALPRACTICE AND THE TORT SYSTEM IN ILLINOIS*, 2 (2005).

29. *Id.* at 20.

30. *Id.*

31. *Id.* at 22.

32. *Id.*

33. VIDMAR, *supra* note 28, at 22.

34. *Id.*

35. *Id.*

36. Mike Fitzgerald, *Doctor Insurers' Rates and Perks Up*, BELLEVILLE NEWS-DEMOCRAT, Jan. 1, 2006; ISMIE Holdings Inc. Registration Statement Under the Securities Act of 1933, Amendment No. 3 to Form S-4, Feb. 14, 2000.

37. Keith A. Hebeisen, *Caps on Damages Reward Insurers at the Expense of Those Injured or Killed by Medical Malpractice*, TRIAL J., Illinois Trial Lawyer's Ass'n, Winter 2006, at 10 (citing ISMIE data set forth in its annual statements submitted to the Illinois Division of Insurance).

because of the increases in population and the number of doctors practicing in the state, and the prevalence of medical errors.³⁸ Instead, the data shows an opposite trend in both case filings and claims paid since 1998. So, the myth of the sue-happy patient does not hold up to scrutiny.

IV. TOTAL ANNUAL INDEMNITY PAYMENTS HAVE DECLINED IN RECENT YEARS IN ILLINOIS

Medical malpractice insurers blame the dramatic increase in premiums in recent years on an allegedly enormous increase in payouts. For instance, the American Medical Association (AMA) claims that physicians insured by ISMIE experienced a premium rate increase of 35.2% in July 2003 because of a whopping 59% increase in payouts.³⁹ Not surprisingly, while citing such statistics, these special interest groups never mention the total annual indemnity payments made over the last several years. Why? Because the data exposes the falseness of their claim.

The figures from ISMIE's own financial records show that while it raised premiums dramatically beginning in 2003, its paid losses between 2000 and 2005 remained very stable.⁴⁰ In 2000, ISMIE paid claims totaling \$163,800,000, while taking in premiums of \$164,800,000.⁴¹ In 2001, it paid claims of \$141,300,000, while taking in premiums of \$209,000,000.⁴² In 2002, its payouts totaled \$158,100,000, while premiums totaled \$265,600,000.⁴³ In 2003, its payouts totaled \$165,200,000, while premiums totaled \$364,300,000. In 2004, ISMIE's paid losses totaled \$153,400,000, while its premiums totaled an astonishing \$425,300,000.⁴⁴ Finally, in 2005, ISMIE's paid losses totaled \$142,600,000, while its premiums totaled \$401,100,000.⁴⁵ Statewide, medical malpractice insurers had an even better

38. From 1993 to 2003, the population of Illinois increased from approximately 21,100,000 to approximately 23,900,000. From 1993 to 2003, the number of total patient care doctors in Illinois rose from 24,514 to 30,264. VIDMAR, *supra* note 28, at 75-76.

39. American Medical Association, *America's Medical Liability Crisis Background*, <http://www.ama-assn.org/ama/pub/category/12386.html> (last visited Feb. 5, 2006).

40. JAY ANGOFF, *FALLING CLAIMS AND RISING PREMIUMS IN THE MEDICAL MALPRACTICE INSURANCE INDUSTRY* 2, 4, 7 (2005) (citing data derived from ISMIE's five year historical data contained in its 2004 annual statement filed with the Illinois Division of Insurance); ISMIE Mutual Ins. Co., Annual Statement for 2005, filed with the Illinois Division of Insurance, Exhibit of Premiums and Losses (statutory page 14).

41. *Id.* at 7.

42. *Id.*

43. *Id.*

44. *Id.* at 2, 7 (ISMIE's premiums and payouts cited are all gross figures, i.e., before accounting for reinsurance).

45. ISMIE Mutual Ins. Co., Annual Statement for 2005, filed with the Illinois Division of Insurance, Exhibit of Premiums and Losses (statutory page 14).

ratio between premiums and payouts than ISMIE. For instance, in 2000, Illinois medical malpractice insurers paid claims totaling \$332,924,227, while taking in premiums of \$393,725,344.⁴⁶ In 2001, they paid claims totaling \$323,015,606, while taking in premiums of \$432,425,486.⁴⁷

These figures illustrate the lack of any correlation between premiums received and claims paid by ISMIE over the last several years.⁴⁸ Payouts have remained essentially flat with only minor fluctuations, while premiums have skyrocketed. Comparing 2000 with 2004, losses paid actually decreased by 6.3%, while premiums increased by 158.1%.⁴⁹ Clearly, these figures belie the contention that ISMIE's 35.2% rate increase in 2003 was due to an increase in payouts. Indeed, at the hearing before the Director of Insurance seeking approval for its 2005 rate increase, an ISMIE official admitted that the 35.2% increase in 2003 was not triggered by payouts made in the preceding years.⁵⁰

Nationally, the picture is the same. Jay Angoff, the former Missouri Insurance Director, studied the 15 largest medical malpractice insurers in the nation, of which ISMIE is one, and analyzed their performance from the years 2000 to 2004.⁵¹ He ascertained that during that five year period, these insurers doubled their premiums collected, while their claims payouts remained essentially stable.⁵² In fact, in 2004, these major insurers took in approximately three times more in premiums than they paid out in claims.⁵³ As a result, they have far more surplus, i.e., money over and above the funds set aside to pay estimated future claims, than is required by the

46. AMERICANS FOR INSURANCE REFORM, MEDICAL MALPRACTICE INSURANCE: STABLE LOSSES/UNSTABLE RATES IN ILLINOIS 7 (2003), available at <http://www.insurance-reform.org/StableLossesIL.pdf> (The data is current only through 2001) [hereinafter AM. FOR INS. REFORM].

47. *Id.*

48. ANGOFF, *supra* note 40, at 7 (citing data derived from 2004 annual statement filed with Illinois Division of Insurance).

49. *Id.*

50. Ill. Dept. of Fin and Prof'l Regulation, In the Matter of the Medical Malpractice Rate Increase of: ISMIE Mutual Insurance, Hearing No. 05-HR-0771 (2005), at 94-98 (Sept. 27, 2005) & In the Matter of the Medical Malpractice Rate Increase of: ISMIE Indemnity Company, Hearing No. 05-HR-0772 (2005), available at <http://www.idfpr.com/DOI/pressRelease/pr05/092705MM.pdf> [hereinafter Rate Hearings]. Under certain circumstances, Public Act 94-677 requires the Department of Financial and Professional Regulation, Division of Insurance, to conduct public hearings to determine whether medical liability insurance rates are excessive, inadequate or discriminatory pursuant certain statutory criteria. If the insurer's rate increase is greater than 6%, the Division of Insurance must hold a hearing. The public hearing regarding ISMIE's 2005 rate increase was held on September 27, and November 9, 2005. *Id.* at 2-5.

51. ANGOFF, *supra* note 40, at 1.

52. *Id.* at 1.

53. *Id.* at 8.

National Association of Insurance Commissioners.⁵⁴ ISMIE, for example, now has almost double the amount of surplus required.⁵⁵

V. WHILE JURY AWARDS MAY HAVE INCREASED, ISMIE'S INDEMNITY PAYMENTS HAVE NOT

Instead of highlighting how much they pay out in indemnity claims, insurers cry that large jury awards are increasing in frequency and amount.⁵⁶ For instance, the Illinois State Medical Society claimed that the average jury verdict in Cook County increased by roughly 300% from 1998 to 2003.⁵⁷ However, such statistics are misleading.⁵⁸

First, it is important to note that jury verdicts account for a very small percentage of indemnity payments. Only about 10% of medical malpractice lawsuits ever go to jury verdict.⁵⁹ Moreover, there is a misperception perpetuated by the AMA that juries favor patients in medical malpractice cases.⁶⁰ On the contrary, juries are biased in favor of doctors. Nationally, plaintiffs lose 70% of the time in medical malpractice jury trials, and in Illinois, the loss rate is similar.⁶¹ Interestingly, judges find for plaintiffs more often than juries.⁶² However, the amount insurers actually pay on those verdicts is never revealed to the public by the Illinois State Medical Society.

Curiously, while they contend that verdicts have increased substantially, ISMIE's claims data shows that indemnity payments have remained essentially flat.⁶³ Considering that settlements are allegedly driven by verdicts, if the average verdict increased by roughly 300% from 1998 to 2003, ISMIE's indemnity payouts should also have increased by 300%. On

54. *Id.* at 4, 19.

55. *Id.* at 19.

56. Carolyn Victoria J. Lees, *The Inevitable Reevaluation of Best v. Taylor in Light of Illinois' Health Care Crises*, 25 N. ILL. U. LAW REV. 217, 218 (2005).

57. Ill. St. Med. Soc'y, *The Medical Litigation Crisis*, 3 available at <http://www.isms.org/realmedicine/info/MedicalLitigationCrisis.pdf> (last visited Feb. 7, 2006) [hereinafter Ill. St. Med. Soc'y].

58. The Illinois State Medical Society and ISMIE have an incestuous relationship. Through a shared services agreement, they share high level employees, support staff, offices and costs, and have a common employer, Illinois State Medical Insurance Services, Inc. (ISMIS). Rate Hearings, *supra* note 50, at 84-85 (Nov. 9, 2005), 98-102 (Nov. 9, 2005), 221-30 (Sept. 27, 2005).

59. VIDMAR, *supra* note 28, at 48.

60. BAKER, *supra* note 23, at 74.

61. *Id.*; VIDMAR, *supra* note 28, at 26-27.

62. BAKER, *supra* note 23, at 73.

63. ANGOFF, *supra* note 40, at 7 (Data contained in Table 2, citing data derived from 2004 annual statement filed with Illinois Division of Insurance).

the contrary, ISMIE's annual payouts have not increased at all.⁶⁴ In fact, 2004 payments decreased 6.3% from 2000.⁶⁵ The conclusion must be that these large verdicts are having little impact on annual indemnity payouts.

What are the reasons for this counter-intuitive result? First, since only 10% of malpractice cases are decided by jury verdict and plaintiffs win only 30% of the time, verdicts account for a small percentage of claims paid. Furthermore, rather than large verdicts inflating settlement value, defense verdicts actually deflate settlement value. Plaintiffs, knowing that juries are biased in favor of doctors, discount settlements accordingly. For example, a plaintiff may sustain serious permanent injuries and believe that a jury should award \$1,000,000 if malpractice is proven. However, the plaintiff knows that statistically a jury will find in favor of the doctor seven out of ten times. In determining settlement value, the plaintiff factors in this high loss ratio and arrives at an amount which is substantially less than \$1,000,000.

Furthermore, Dr. Vidmar determined that for several reasons the verdict awarded is frequently not the amount actually paid.⁶⁶ Often the parties enter into high-low settlement agreements before the jury returns a verdict.⁶⁷ Many cases settle for the policy limits of coverage after the verdict, usually \$1,000,000 or \$2,000,000.⁶⁸ Occasionally, the trial judge reduces or overturns the verdict at the post-trial motion stage⁶⁹ or there are setoffs from non-physician defendants who settle before or during trial.⁷⁰ Sometimes the appellate court reverses the jury's verdict.⁷¹ In any event, the insurer's exposure is ultimately capped by the policy limits of coverage.⁷² Illinois State Medical Society is misleading its constituency and the public when it doesn't tell the full story about the relationship between jury verdicts and annual indemnity payouts— verdicts are not the driving force behind increasing premiums.

64. *Id.*

65. *Id.*

66. VIDMAR, *supra* note 28, at 28-30, 47-49.

67. *Id.*

68. Most of the policies that ISMIE writes have limits of \$1,000,000 or \$2,000,000. Rate Hearings, *supra* note 50, at 123 (Sept. 27, 2005); VIDMAR, *supra* note 28, at 28-29, 47-49.

69. VIDMAR, *supra* note 28, at 28-29, 47-49.

70. *Id.*

71. *Id.*

72. Although most of ISMIE's policies have limits of \$1,000,000 or \$ 2,000,000, under the arrangement it has with its reinsurers, ISMIE's actual exposure is generally capped at \$500,000 per lawsuit, with the reinsurer indemnifying ISMIE for any amount over that up to the policy limits. Rate Hearings, *supra* note 50, at 63-69 (Sept. 27, 2005).

VI. MADISON AND ST. CLAIR COUNTIES ARE NOT “JUDICIAL HELLHOLES”

Cap proponents who claim that jury verdicts are increasing in size and frequency focus particularly on Madison and St. Clair counties in southern Illinois. The American Tort Reform Association has labeled them “judicial hellholes,” contending that juries in those counties hand out frequent and excessive verdicts to plaintiffs in civil litigation cases and that personal injury lawyers seek out these counties “because they know they will produce a positive outcome”⁷³ Again, the data does not support these claims.

Due to the controversy, Dr. Vidmar did a detailed study of medical malpractice jury trials in these counties.⁷⁴ From 1992 to 2005, there were twenty-six such trials in Madison County, of which plaintiffs lost seventeen.⁷⁵ Of the verdicts for plaintiffs, only one award exceeded \$1,000,000.⁷⁶ In St. Clair County, there were fourteen medical malpractice jury trials from 1993 to 2003, of which plaintiffs lost twelve.⁷⁷ Of the two verdicts for plaintiff, only one was in excess of \$1,000,000, but that case was reversed on appeal.⁷⁸ In the United States District Court for the Southern District of Illinois, there were eight medical malpractice jury trials between 1992 and 2003, of which plaintiffs lost six.⁷⁹ The two plaintiff verdicts were for \$375,000 and \$100,000.⁸⁰ Thus, of these forty-eight jury trials, plaintiffs lost 73% of the time, and there was only one verdict upheld over one million dollars. Rather than being “judicial hellholes,” these counties are actually physician-friendly in medical malpractice cases.

VII. THE MEDICAL MALPRACTICE INSURANCE INDUSTRY MISREPRESENTS ITS LOSSES THROUGH MISLEADING ACCOUNTING PRACTICES

In order to convince the public and lawmakers that caps are necessary, medical malpractice insurers allege that they pay more in indemnity claims than they receive in premiums. For instance, in 2001, a coalition of Florida insurance companies, hospitals and medical lobbyists claimed that medical liability insurers nationally paid out \$1.40 in losses for every \$1.00 in

73. AMERICAN TORT REFORM ASSOCIATION, JUDICIAL HELLHOLES 2005, <http://www.atra.org/reports/hellholes/> (last visited Feb. 5, 2006).

74. VIDMAR, *supra* note 28, at 51-64.

75. *Id.* at 52.

76. *Id.*

77. *Id.* at 58.

78. *Id.*

79. *Id.* at 62.

80. VIDMAR, *supra* note 28, at 62.

premiums collected.⁸¹ ISMIE claimed to have “paid out \$1.19 for every \$1.00 in premium income in 2002.”⁸² These disingenuous claims are based upon misleading accounting practices.⁸³

In setting premiums for a particular year, an insurance company first estimates the amount it will eventually pay out for claims covered by policies in that year.⁸⁴ However, there is approximately a ten year lag between when premiums are received and when all of the claims arising in that policy year are paid.⁸⁵ In other words, when setting a premium, an insurance company does not know what its losses will be for that particular rate setting year. Consequently, the insurance company must project what those losses will be. Misleadingly, this estimate is called an “incurred loss,” rather than, more appropriately, a “projected loss.”⁸⁶ On the other hand, a company’s “paid losses” are the amount that they eventually pay out over that ten year period for all claims arising in that particular year.⁸⁷ For example, in setting premiums for calendar year 2006, an insurance company may project losses of \$400,000,000 for all claims arising in calendar year 2006. However, when all of the claims which arose in calendar year 2006 are paid by the year 2016, the total actual loss on those claims may be only \$216,000,000.

Unfortunately, there are no standards, other than in the state of California, to regulate how an insurance company must calculate its projected losses.⁸⁸ As a result, medical liability insurers routinely inflate their projected losses for a given year to justify sharp increases in premiums and the need for damage caps.⁸⁹ These projected losses ultimately have little relationship to what is eventually paid out in actual losses. One study examined the industry’s reported projected losses and the actual losses over

81. THE FOUNDATION FOR TAXPAYER AND CONSUMER RIGHTS, FALSE ACCOUNTING: HOW THE MEDICAL MALPRACTICE INSURANCE COMPANIES INFLATE LOSSES TO JUSTIFY SUDDEN SURGES IN RATES AND TORT REFORM, 8 (Dec. 29, 2005) <http://www.consumerwatchdog.org/mapractice/rp/5714.pdf> [hereinafter FALSE ACCOUNTING].

82. ISMIE MUTUAL INSURANCE COMPANY, 2002 ISMIE ANNUAL REPORT, 2, available at <http://www.ismie.com/about/2002AR.pdf> (last visited March 3, 2006) [hereinafter ISMIE REPORT].

83. *Id.* at 8.

84. FALSE ACCOUNTING, *supra* note 81, at 6-7.

85. *Id.*

86. *Id.* at 7. For clarity, incurred losses will hereafter be referred to as projected losses.

87. *Id.* at 6-8.

88. *Id.* at 6.

89. *Id.* at 10-13.

a nine year period and found that malpractice insurers overstated projected losses by 46%.⁹⁰

Thus, when ISMIE claims to have “paid out \$1.19 for every \$1.00 in premium income in 2002,” it sounds as if it had a bad year.⁹¹ However, that statement must be based upon its overestimated and not yet paid projected losses, because in 2002, ISMIE paid out claims totaling \$158,100,000 and had premium income of \$265,600,000, hardly a loss for that year.⁹² Unwittingly, the news media reports that medical malpractice insurers are losing money at an alarming rate, and insurers let this misperception stir up public and legislative support for caps.⁹³

Historically, medical liability insurers in Illinois had virtually unlimited discretion in calculating projected losses.⁹⁴ In his statement to the Illinois Division of Insurance regarding ISMIE’s rate increase, Missouri’s former Insurance Director Jay Angoff urged the adoption of standards that actuaries must follow in calculating projected losses and other assumptions to justify rate increases, as is the case in California’s regulatory system.⁹⁵ Such standards “would substantially reduce the arbitrariness that exists in the current ratemaking process.”⁹⁶

In addition to making projected losses bear some relationship to actual losses, increased regulation would prohibit ISMIE from factoring into its ratemaking such expenses as the \$4,900,000 “deferred compensation” payment made to outgoing Chief Operating Officer Donald Udstuen shortly before he pleaded guilty to taking kickbacks on state contracts.⁹⁷ Regulation would also prohibit factoring into rate increases the million dollar salary and low interest mortgage loan of nearly a million dollars given to its current chief executive officer.⁹⁸ Furthermore, it would likely prohibit

90. FALSE ACCOUNTING, *supra* note 81, at 13. From 1986 to 1995, ISMIE overestimated its projected losses by 15.2% or \$189,500,000. Statement of Jay Angoff to the Department of Financial and Professional Regulation, Division of Insurance, In The Matter Of The Medical Malpractice Rate Increase of ISMIE Mutual Insurance Company, September 27, 2005, Exhibit B.

91. ISMIE REPORT, *supra* note 82, at 2.

92. ANGOFF, *supra* note 40, at 7 (citing data derived from 2004 annual statement filed with Illinois Division of Insurance).

93. FALSE ACCOUNTING, *supra* note 81, at 8.

94. Statement of Jay Angoff, *supra* note 90, at 7-8.

95. *Id.*

96. *Id.* Mr. Angoff analyzed ISMIE’s annual statements for the years 2002, 2003 and 2004 and found that its 45.2% rate increase during those years was unjustified by either its paid losses or its projected losses. *Id.* at 8-9.

97. Tim Novak & Steve Warmbir, *Witness in Probe of Ryan Era Got 4.9 Mil. Goodbye*, CHI. SUN-TIMES, May 27, 2003, at 8. This payment was made to Udstuen in 2002, the year before ISMIE raised premiums by 35%. *Id.* Hebeisen, *supra* note 37, at 32.

98. Fitzgerald, *supra*, note 36, at 1A. These perks were given at about the time that ISMIE was raising rates on its insureds significantly.

ISMIE from gouging a 6.5% broker fee from physicians who don't use a broker, its current practice with 38% of policyholders.⁹⁹

VIII. PHYSICIANS ARE NOT FLEEING ILLINOIS

In an attempt to panic the public into demanding caps, the medical lobby has issued dire warnings that physicians are “fleeing Illinois in search of more affordable coverage and leaving Illinois patients bereft of health care options, as the number and availability of physicians declines.”¹⁰⁰ Illinois State Medical Society and ISMIE have suggested that physicians are leaving in such great numbers that “it is as if the Illinois Department of Transportation erected signs at our state’s borders saying: ‘[d]octors not wanted – enter at your own risk.’”¹⁰¹ However, the data does not support these ominous and absurd allegations.

As part of his study, Dr. Vidmar sought to determine whether the number of doctors in Illinois is declining, as claimed by the AMA.¹⁰² Using the AMA’s data, current through 2003,¹⁰³ Dr. Vidmar examined all active non-federal patient care physicians, and in particular, obstetrician/gynecologists and neurosurgeons, the two subspecialties whose numbers purportedly have been most affected by the liability insurance increase.¹⁰⁴

The trend Dr. Vidmar found contradicts the AMA’s assertion that the number of physicians in Illinois is plummeting. Instead, the AMA’s own data shows that the number of physicians in Illinois steadily increased between 1993 and 2003, from 24,514 to 30,264, a net gain of 5,750.¹⁰⁵ Equally important, the number of physicians per capita also steadily increased from 211 to 239 per 100,000 Illinoisans.¹⁰⁶ Likewise, during that same time period, the number of obstetrician/gynecologists steadily

99. Rate Hearings, *supra* note 50, at 186-205 (Nov. 9, 2005). For ISMIE’s interesting explanation of why it charges a 6.5% broker fee on the 38% of policyholders who do not use a broker, see *id.*

100. Lees, *supra* note 56, at 218 (citing American Medical Association, *Medical Liability Reform – NOW!*, at 4 (Mar. 26, 2004), available at <http://www.ama-assn.org/go/mlrnow>).

101. Ill. St. Med. Soc’y, *supra* note 57, at 2.

102. VIDMAR, *supra* note 28, at 73.

103. Dr. Vidmar relied on American Medical Association, *Physician Characteristics and Distribution in the U.S.*, 2005 Edition.

104. VIDMAR, *supra* note 28, at 73-77. Dr. Vidmar studied all physicians except those employed by the federal government and its agencies, because their tort liability is assumed by the federal government, and thus, they are not affected by liability insurance premiums. In addition, he looked only at physicians in Illinois with an active license who are focused on patient care. *Id.* at 73-75.

105. *Id.* at 75.

106. *Id.* at 76.

increased from 1,596 to 1,814, and the number of neurosurgeons increased from 191 to 212.¹⁰⁷ Dr. Vidmar also examined the number of physicians in Madison and St. Clair counties because of claims of mass exodus from these “judicial hellholes.”¹⁰⁸ Contrary to the hype, the data shows that the number of physicians in those counties remained steady from 1993 to 2003.¹⁰⁹ Accordingly, the AMA’s own data contradicts its claims.¹¹⁰

Although the AMA’s data was current only through 2003, *Crain’s Chicago Business*, a well-respected publication, recently reported that the number of licensed doctors in Illinois rose by 9% in the last three years, despite assertions by the medical lobby that physicians are fleeing to neighboring states with lower malpractice premiums.¹¹¹ Further, obstetrician/gynecologists and neurosurgeons in Illinois increased by 2% and 3%, respectively, in the past year.¹¹² Even more telling, in Indiana, a cap state for many years, the number of licensed physicians declined by 18% between 2002 and 2005.¹¹³ *Crain’s* concluded that “licensing data for Illinois and surrounding states doesn’t reveal any correlation between the physician population and liability caps.”¹¹⁴ A spokesperson for the Illinois Department of Financial and Professional Regulation reported to *Crain’s* that: “We’re not seeing an unstable market for docs in Illinois.”¹¹⁵

Likewise, nationally, the United States General Accounting Office (GAO) determined that there is no widespread healthcare access crisis caused by rising medical malpractice premiums.¹¹⁶ In its report to congressional requesters, the GAO found that the AMA’s claims were inaccurate, unsubstantiated, exaggerated, or to the extent that there were a few access problems, attributable to other explanations.¹¹⁷ Rather than accept the GAO’s findings, the AMA tried to quash the report.¹¹⁸

The Wisconsin Supreme Court in *Ferdon v. Wisconsin Patients Compensation Fund*, relying on this non-partisan GAO study and other current research, determined that caps on non-economic damages do not attract or

107. *Id.* at 75.

108. VIDMAR, *supra* note 28, at 51-64.

109. *Id.* at 77-82.

110. *Id.* at 82.

111. Bret Chase, *Caps or No, Ill. Adds to Doc Totals*, *CRAIN’S CHI. BUS.*, Sept. 11, 2005, at 1.

112. *Id.*

113. *Id.*

114. *Id.*

115. *Id.*

116. U.S. GEN. ACCT. OFF., ANALYSIS OF MEDICAL MALPRACTICE: IMPLICATIONS OF RISING PREMIUMS ON ACCESS TO HEALTH CARE 7 (Aug. 2003).

117. *Id.* at 5, 13, 16-18.

118. *Id.* at 38.

keep doctors in a state.¹¹⁹ Furthermore, the court concluded that the absence of caps do not influence doctors to leave a state.¹²⁰ Contrary to the widespread hype from medical trade associations that doctors are fleeing non-cap states, caps do not affect physicians' migration. Rather than fleeing Illinois, physicians are instead *choosing* to practice medicine in Illinois.

IX. INSURANCE INDUSTRY MISMANAGEMENT AND DECLINE IN INVESTMENTS, NOT DAMAGE PAYOUTS, CAUSE INCREASES IN MALPRACTICE PREMIUMS

The insurance and medical lobbies adamantly claim that caps on non-economic damages reduce premiums.¹²¹ However, experience shows otherwise. Weiss Ratings Inc., an esteemed insurance industry analyst, studied the affect of caps on physicians' premiums.¹²² The authors of the study concluded that physicians' premiums were rapidly increasing despite caps.¹²³ In fact, it found that between 1991 and 2002, physicians in the nineteen states with caps experienced a significantly larger increase in premiums than their colleagues in non-cap states.¹²⁴ In cap states, doctors suffered a 48.2% increase in premiums,¹²⁵ while in non-cap states, doctors' premiums rose by only 35.9%.¹²⁶ Furthermore, only 10.5% of cap states experienced steady or decreasing premiums, while 18.7% of non-cap states experienced steady or decreasing premiums.¹²⁷ The authors, who did not expect this result, concluded that "[t]here are other, far more important factors driving the rise in med mal premiums than caps or med mal payouts."¹²⁸ Weiss determined that by pushing for caps, insurance companies and their allies are distracting the public from the industry's mismanagement and "using the insurance crisis opportunistically to push tort reform."¹²⁹

119. 701 N.W.2d 440, 485-87 (Wis. 2005). In *Ferdon*, the court held that the \$350,000 limitation on non-economic damages (indexed to inflation to \$410,322) violates the Wisconsin Constitution. *Id.* at 491.

120. *Id.* at 485.

121. Ill. St. Med. Soc'y, *supra* note 57, at 3-5.

122. MARTIN D. WEISS ET AL., MEDICAL MALPRACTICE CAPS (Weiss Ratings Inc. 2003).

123. *Id.* at 3.

124. *Id.* at 7-8.

125. *Id.* at 7.

126. *Id.* at 7-8.

127. *Id.* at 8.

128. WEISS, *supra* note 122, at 8.

129. *Id.* at 14.

Shamefully, while they push for such legislation, the insurance industry knows that caps do not reduce premiums. In its filing to the Texas Department of Insurance seeking a rate increase despite the recent enactment of a cap on non-economic damages, GE Medical Protective Company, one of the nation's largest insurers, stated that a rate increase was necessary because "[n]on-economic damages are a small percentage of total losses paid. Capping non-economic damages will show a loss savings of 1.0%."¹³⁰ Similarly, when South Carolina's largest medical malpractice insurer, Marsh USA, was asked by the government what impact a \$250,000 non-economic damage cap would have on premiums, a high ranking executive would not guarantee that caps would lower premiums.¹³¹ In 2003, an assistant vice president of SPCIE, a major California medical malpractice insurer, testified that California's \$250,000 cap on non-economic damages does not substantially reduce the risk to insurers.¹³²

Here in Illinois, after the General Assembly passed the \$500,000 cap on non-economic damages in May 2005, ISMIE raised malpractice rates on its corporate and partnership policies by over 20% in June.¹³³ At the hearing on these rate increases, ISMIE executives refused to say when or if rates would come down as a result of the damage cap.¹³⁴ This refusal occurred despite the fact that ISMIE touted to physicians, lawmakers and the public that capping non-economic damages "is the single most important reform that could be enacted" to lower insurance premiums.¹³⁵ Medical malpractice insurers know what the Weiss study concluded: that "[t]he imposition of caps will not make a significant dent in the problem . . . It is no substitute for longer-term, fundamental solutions that address the actual factors behind the med mal crisis."¹³⁶

Weiss Ratings identifies six factors that are fueling the rise in insurance rates, including medical cost inflation, the decrease in the number of medical malpractice insurers, the cyclical nature of the insurance market,

130. Letter from Melissa Coker, Regulatory Specialist, GE Medical Protective Company to Hon. Jose O. Montemayor, Insurance Commissioner, Texas Department of Insurance (Aug. 30, 2003) and attached Memorandum from the Texas Medical Protective Company – Texas Physicians and Surgeons Actuarial Tort Reform Memorandum, at <http://www.consumerwatchdog.org/malpractice/rp/2059.pdf> (last visited on Mar. 23, 2006).

131. Letter from Timothy J. Ward, Assistant Vice President Marsh USA to Michael N. Couick, Senate Judiciary Committee (February 7, 2005) at <http://www.consumerwatchdog.org/malpractice/rp/1810.pdf> (last visited on Mar. 23, 2006).

132. Written testimony of James Robertson, Assistant Vice President, SCPIE, in response to orders by the Court, 4 (Apr. 30, 2003) at <http://www.consumerwatchdog.org/malpractice/rp/2058.pdf> (last visited on Mar. 23, 2006).

133. Rate Hearings, *supra* note 50, at 83 (Sept. 27, 2005).

134. *Id.* at 144-49 (Nov. 9, 2005).

135. Ill. St. Med. Soc'y, *supra* note 57, at 9, 13.

136. WEISS, *supra* note 122, at 15.

and the decline in investment income.¹³⁷ During the period 1991 to 2002, the medical rate of inflation was 75%, which directly impacts the economic portion of settlements and verdicts.¹³⁸ There have also been a shrinking number of medical malpractice carriers since 1997, thereby reducing supply and putting upward pressure on premiums.¹³⁹

The most significant factors, however, are the cyclical nature of the casualty insurance market and the decline in investment income.¹⁴⁰ The insurance industry is subject to a recognized and predictable economic cycle.¹⁴¹ Insurers make most of their profit from investments, which fluctuate with the stock market and interest rates.¹⁴² Premium dollars are invested from the time they are collected until claims incurred in that policy year are paid. This practice is otherwise known as investing the “float.”¹⁴³ In the medical liability insurance industry, this is usually a five to ten year period.¹⁴⁴ When the investment market is good, insurance companies slash premiums to attract policyholders and insure risky doctors in an effort to raise investment capital.¹⁴⁵ The insurers are willing to severely under-price policies and take on poor risks at the expense of underwriting losses because they are reaping huge profits investing the float.¹⁴⁶

But what goes up must come down. When their stock investments turn south, coupled with declining interest rates on their bond holdings, they begin to feel the effects of their mismanagement.¹⁴⁷ As a result, they raise the standards for insurability and increase premiums drastically, ushering in a “medical malpractice crisis” period, as happened in the mid-70s, mid-80s and at the beginning of this decade.¹⁴⁸ If instead verdicts were responsible for these periodic sharp increases in premiums, juries must have awarded

137. *Id.* at 9-12.

138. *Id.*

139. *Id.* at 11-12.

140. ILL. TRIAL LAW. ASS’N, MEDICAL MALPRACTICE INSURANCE AND DOCTOR DISCIPLINE ISSUES 7-8 (Feb. 2005) at http://www.iltla.com/Medical%20Malpractice/ITLA_med_mal_position_paper_05.pdf [hereinafter ITLA, INSURANCE ISSUES]; ILL. TRIAL LAW. ASS’N, REPORT TO THE ILLINOIS GENERAL ASSEMBLY REGARDING MEDICAL MALPRACTICE CRISIS 5-6 (2003) [hereinafter ITLA, REPORT TO ILL. GEN. ASS.].

141. ITLA, INSURANCE ISSUES, *supra* note 140, at 7.

142. AM. FOR INS. REFORM, *supra* note 46, at 7.

143. JOANNE DOROSHOW & J. ROBERT HUNTER, INSURANCE “CRISIS” OFFICIALLY OVER – MEDICAL MALPRACTICE RATES HAVE BEEN STABLE FOR A YEAR 3 (Americans for Insurance Reform, Feb. 2006), at <http://insurance-reform.org/pr/MMSOFTMARKET.pdf> [hereinafter DOROSHOW & HUNTER].

144. *Id.*

145. WEISS, *supra* note 122, at 9.

146. *Id.*; DOROSHOW & HUNTER, *supra* note 143, at 3.

147. WEISS, *supra* note 122, at 9.

148. *Id.*; AM. FOR INS. REFORM, *supra* note 46, at 3.

giant sums in the mid-70s, taken a sabbatical for ten years, awarded giant sums in the mid-80s, taken more time off, and then awarded giant sums in the beginning of this decade.¹⁴⁹ Donald J. Zuk, Chief Executive Officer of SCPIE Holdings, Inc., recognizing that the crisis is industry created, stated that “I don’t like to hear insurance company executives say it’s the tort system - - it’s self-inflicted.”¹⁵⁰

ISMIE’s 35% increase in premiums in 2003 came on the heels of the company’s 18% loss of investment income in 2002, due in part to losses from the sale of stock held in scandal ridden World Com, Tyco and Quest Securities.¹⁵¹ In addition, the bond market, another big source of ISMIE’s investment income, experienced a reduction in interest rates.¹⁵² At the same time, reinsurance rates for medical malpractice carriers increased rapidly, due in part to the events of September 11, 2001.¹⁵³ Thus, while medical malpractice insurers’ payouts in settlements and jury verdicts closely track medical inflation, premiums do not.¹⁵⁴ Rather, premiums spike and fall in step with the economy and the insurance industry’s market investments.¹⁵⁵ Appallingly, not one seriously injured medical malpractice victim’s pain and suffering played any part in this cycle.

X. CAPS HAVE NOT REDUCED PREMIUMS IN OTHER STATES

Cap proponents cite California’s Medical Injury Compensation Relief Act (MICRA) as a shining example of the success of cap legislation in decreasing premiums.¹⁵⁶ However, that reliance is sorely misplaced. In 1975, in response to rising medical malpractice rates, California enacted MICRA which, among other provisions, placed a \$250,000 cap on non-economic damages.¹⁵⁷ Despite the legislation, medical malpractice premiums continued to rise dramatically. From 1976 to 1988, premiums rose 190%, with increases higher than the national average.¹⁵⁸

149. DOROSHOW & HUNTER, *supra* note 143, at 2.

150. Rachel Zimmerman & Christopher Oster, *Assigning Liability: Insurer’s Missteps Helped Provoke Malpractice ‘Crisis’ – Lawyers Alone Didn’t Cause Premiums to Skyrocket; Earlier Price War a Factor – Delivering Ms. Kline’s Baby*, WALL ST. J., June 24, 2002, at A1.

151. ITLA, INSURANCE ISSUES, *supra* note 140, at 7.

152. *Id.*

153. *Id.*

154. AM. FOR INS. REFORM, *supra* note 46, at 1.

155. *Id.*

156. CAL. CIV. CODE § 3333.2 (West 2006); Lees, *supra* note 56, at 223.

157. CAL. CIV. CODE § 3333.2 (West 2006).

158. ITLA, INSURANCE ISSUES, *supra* note 140, at 4.

Finally, citizens took matters into their own hands, and in 1988, enacted Proposition 103.¹⁵⁹ Proposition 103 rolled back insurance rates up to 20%, froze premiums, refunded millions of dollars in past overcharges to physicians, and required stringent government oversight of rate increases.¹⁶⁰ It also allowed consumers to challenge proposed rate increases and made the insurance commissioner an elected position.¹⁶¹ As a result of this voter initiative, there was an immediate reduction in medical malpractice insurance rates, and by 1991, premiums had decreased by 20.2%.¹⁶² Additionally, insurers refunded about \$135,000,000 to healthcare providers by 1995.¹⁶³

After the enactment of MICRA, but before the ratification of Proposition 103, premiums in California increased faster than the national average, rising precipitously in the mid-1980s during that decade's insurance crisis.¹⁶⁴ In fact, rates nearly tripled during that ten year period, despite the very regressive cap.¹⁶⁵ However, following the passage of Proposition 103's insurance reforms, premiums dropped sharply, continued to decrease, and then stabilized, contrary to national trends.¹⁶⁶ Not surprisingly, cap proponents prefer to highlight MICRA and its \$250,000 cap as the reason for California's successful control of malpractice insurance rates, ignoring Proposition 103. On the contrary, the facts make plain that it was Proposition 103, with its strict control of the medical liability insurance industry, which brought about legitimate reform.¹⁶⁷

Another instance of legitimate reform comes from our neighbor to the north. In 1975, the Wisconsin legislature established the Patients Compensation Fund and the Wisconsin Healthcare Liability Insurance Plan (WHLIP) in response to that decade's "insurance crisis."¹⁶⁸ The legislation

159. 1988 Cal. Legis. Serv. Prop. 103 (West) (codified at CAL. INS. CODE Sect. 1861.01).

160. THE FOUND. FOR TAXPAYER & CONSUMER RTS., HOW INSURANCE REFORM LOWERED DOCTORS' MEDICAL MALPRACTICE RATES IN CALIFORNIA AND HOW MALPRACTICE CAPS FAILED 2 (2003), <http://www.consumerwatchdog.org/malpractice/rp/1008.pdf> [hereinafter FOUNDATION].

161. *Id.*

162. *Id.* at 3.

163. *Id.* at 4.

164. ITLA, REPORT TO ILL. GEN. ASS., *supra* note 140.

165. FOUNDATION, *supra* note 160, at 1.

166. *Id.* at 5.

167. *Id.* at 9.

168. Injured Patients and Families Compensation Fund, WIS. STAT. § 655.27 (2005). In 2003, the Fund was renamed Injured Patients and Families Compensation Fund. WIS. CITIZEN ACTION & WIS. ACAD. OF TRIAL LAW., JUSTICE CAPPED, TILTING THE SCALES OF JUSTICE AGAINST INJURED PATIENTS AND THEIR FAMILIES at 8-9 (2005) [hereinafter WATL, JUSTICE CAPPED]; WIS. ACAD. OF TRIAL LAW., INJURED PATIENTS AND FAMILIES

requires doctors to carry primary insurance with limits of \$1,000,000.¹⁶⁹ The Fund is financed through an annual fee on all healthcare providers, with legislative oversight of the amount of these assessments.¹⁷⁰ The Fund acts like an excess insurer, paying any damage settlement or award that exceeds the primary coverage of \$1,000,000.¹⁷¹ WHLIP provides insurance for any physician who is unable to acquire malpractice insurance on the open market and operates just like a private insurance company.¹⁷² As of 2004, the Fund had a balance of approximately \$741,000,000, with an estimated surplus exceeding \$300,000,000.¹⁷³ For approximately half of the Fund's existence, there have been no caps on non-economic damages in Wisconsin.¹⁷⁴

Key features of the Fund are (1) its not-for-profit status; (2) it pays state salaries as opposed to large executive salaries and perks; and (3) assessments are not heavily contingent on stock and bond market investments.¹⁷⁵ In addition, by having only four assessment classifications, the Fund more evenly distributes the cost of insuring the risk. The fund achieves this more even distribution by moderately increasing the cost to lower risk specialties and thereby reducing the cost to high risk specialties significantly.¹⁷⁶

In 1995, the Wisconsin legislature imposed a \$350,000 non-economic damage cap indexed to inflation, but in July 2005, the Wisconsin Supreme Court in *Ferdon v. Wisconsin Patients Compensation Fund* held that capping non-economic damages was unconstitutional.¹⁷⁷ In their decision, the court painstakingly analyzed the performance of the Fund during both cap and non-cap periods and concluded that “[t]he Fund has flourished both with and without a cap.”¹⁷⁸ The Fund, which is essentially an insurer with unlimited exposure (unlike private insurers who always have a policy limit), has more than sufficient capital to fully compensate medical malpractice victims and still show a healthy balance sheet. The court in *Ferdon*, after considering all of the data, correctly concluded that “[w]e

COMPENSATION FUND – A SHORT HISTORY (2005) [hereinafter WATL, INJURED FUND – A SHORT HISTORY].

169. Wis. STAT. § 655.23(4)(b)(2) (2005). The primary insurance policy limits increase from time to time, and have been \$1,000,000 since 1997.

170. WATL, INJURED FUND – A SHORT HISTORY, *supra* note 168.

171. WATL, JUSTICE CAPPED, *supra* note 168, at 8.

172. *Id.* at 8-9.

173. *Ferdon*, 701 N.W.2d at 478.

174. *See id.* at 477-78.

175. WATL, JUSTICE CAPPED, *supra* note 168, at 8-9.

176. *Id.* at 9; WATL, INJURED FUND – A SHORT HISTORY, *supra* note 168.

177. *Ferdon*, 701 N.W.2d at 491; Wis. STAT. § 655.017 (2004); Wis. STAT. § 893.55(f)(d) (Supp. 2005); WATL, JUSTICE CAPPED, *supra* note 168 at 8.

178. *Ferdon*, 701 N.W.2d at 483.

agree with those courts that have determined that the correlation between caps on noneconomic damages and the reduction of medical malpractice premiums or overall health care costs is at best indirect, weak, and remote.”¹⁷⁹

Perhaps the best evidence of the fallacy that caps reduce premiums is the AMA’s own list of “crisis states.” The crisis states are twenty states that the AMA charges are “currently experiencing a medical liability crisis.”¹⁸⁰ However, of those states, six have caps: West Virginia has had caps since 1986, Missouri since 1988, Massachusetts since 1997, Florida since 2002, Nevada since 2002, and Ohio since 2003.¹⁸¹ After caps were passed in Nevada, one insurer raised rates by 93%.¹⁸² Insurance rates in Massachusetts increased 88% between 1998 and 2004.¹⁸³ In Florida, one insurer sought a rate increase of 45% for 2004.¹⁸⁴ After caps were passed in Ohio in 2003, insurance rates increased by 20% the following year.¹⁸⁵ In West Virginia, malpractice insurance rates rose as much as 26% between 2001 and 2002.¹⁸⁶ In Missouri, where insurance companies have had the benefit of caps since 1988, premiums rose by 121% from 2000 to 2003.¹⁸⁷ And this is reportedly the state that doctors in East St. Louis are swimming

179. *Id.* at 485.

180. AMERICAN MEDICAL ASSOCIATION, MEDICAL LIABILITY REFORM – NOW! 9 (2005), <http://www.ama-assn.org/ama1/pub/upload/mm/378/mlrnowoct192005.pdf> (last visited Mar. 27, 2006). The article claims that Arkansas, Connecticut, Florida, Georgia, Illinois, Kentucky, Massachusetts, Mississippi, Missouri, New Jersey, New York, North Carolina, Ohio, Oregon, Pennsylvania, Rhode Island, Washington, Nevada, West Virginia, and Wyoming are currently experiencing a medical liability crisis. *Id.* at 10-22.

181. WEISS, *supra* note 122, at 5; Hebeisen, *supra* note 37, at 27.

182. Joell Babula, *Medical Liability Company Requests Premium Increase*, LAS VEGAS REV.-J., Feb. 11, 2003 at 2B; Joell Babula, *State Insurance Program Holds Off On Lowering Rates*, LAS VEGAS REV.-J., Aug. 14, 2002 at 1B.

183. *Mass. Doctors Decry Latest Malpractice Hike*, INS. J. (May 18, 2004), at <http://www.insurancejournal.com/news/east/2004/05/18/42338.htm>; Ralph Ranalli, *Malpractice Plan Would Limit Trials*, BOSTON GLOBE, Nov. 13, 2003, at A1, available at http://www.boston.com/news/local/articles/2003/11/13/malpractice_plan_would_limit_trials/.

184. Julie Kay, *Medical Malpractice; Despite Legislation that Promised to Rein in Physicians’ Insurance Premiums, Three Firms File for Big Rate Increases*, PALM BEACH DAILY BUS. REV., Nov. 20, 2003, at 10.

185. David Schrag, *Malpractice Costs – Fixing Blame*, MORNING J., July 18, 2004, at A1, available at http://www.morningjournal.com/site/news.cfm?newsid=12386842&BRD=1699&PAG=461&dept_id=46371&rfti=6.

186. Joan Claybrook, President of Public Citizen, Statement Before the West Virginia Senate Committee on Judiciary (Jan. 23, 2003) available at <http://www.citizen.org/congress/civjus/medmal/articles.cfm?ID=8846>.

187. *Mo. Malpractice Claims Fall but Premiums Rise*, INS. J. (Nov. 9, 2004), at <http://www.insurancejournal.com/news/midwest/2004/11/09/47543.htm?print=1>.

the Mississippi to in droves.¹⁸⁸ If caps work, why are these states on the AMA's so-called crisis list?

Other cap states fared no better during this latest "crisis" period. In Maryland, a cap state since 1986, rates increased by 60% in the last two years.¹⁸⁹ In Utah, a cap state since 1996, rates for internists increased between 25% and 35% in 2002.¹⁹⁰ In Alaska, capped since 1997, one medical center reported that its rates increased by 326% from 2001 to 2003.¹⁹¹ Undoubtedly, the experience of these states shows that caps don't reduce doctors' premiums. In fact, the experience of cap and non-cap states during "crisis" periods shows that there is no correlation between damage limitations and malpractice rates, and thus, "taking away the rights of the most seriously injured in our society has been and continues to be a failed public policy."¹⁹²

Here in Illinois, as soon as caps were passed, ISMIE raised rates more than 20% on corporate and partnership accounts,¹⁹³ and then announced another 25% increase for the 2006-2007 premium year.¹⁹⁴ It also announced rate increases for seven medical specialties ranging from 5.9% to 22.2%.¹⁹⁵ All physicians in Jackson County will suffer a rate increase of 11.1%, in Winnebago County 13.3%, and in Grundy County 20%.¹⁹⁶ So, while ISMIE misleadingly claims an average premium reduction of 5.2% for the 2006-2007 year, this comes at the expense of a substantial number

188. Hebeisen, *supra* note 37, at 27.

189. WEISS, *supra* note 122, at 5; M. William Salganik, *33% Increase In Malpractice Premiums OK'd; Approval comes on top of a 28% rise this year; Heated-up reform debate likely; Highest-risk specialists to pay \$150,000 a year*, *BALT. SUN*, Sept. 15, 2004, at 1D.

190. WEISS, *supra* note 122, at 5; Berkeley Rice, *Malpractice premiums: Soaring again*, *MED. ECON.*, Dec. 9, 2002, at 51 available at <http://www.memag.com/memag/article/articleDetail.jsp?id=116951>.

191. *Voice of the Times: Insurance Rates Skyrocket*, *ANCHORAGE DAILY NEWS*, Aug. 20, 2003, at B7.

192. DOROSHOW & HUNTER, *supra* note 143, at 6-7.

193. Rate Hearings, *supra* note 50, at 83 (Sept. 27, 2005). Following the hearings on ISMIE's proposed rate increases in September and November of 2005, the Illinois Department of Financial and Professional Regulation, Division of Insurance, approved ISMIE's requested 20% increase for corporate and partnership accounts, but ordered that ISMIE: (1) freeze the average premium rate and target a rate reduction of 3.5% for premium year 2006-07; (2) rebate excessive premiums received in policy years 2005-06 and 2006-07; (3) give significant discounts to doctors who participate in educational programs designed to improve healthcare; and (4) provide extensive and verifiable data on its rate making process that the Division of Insurance can use to evaluate any future rate increase requests and make this data available to the public and to other insurance companies seeking to write medical malpractice policies in Illinois. Order of March 14, 2006 in Rate Hearings, *supra* note 50.

194. ISMIE Mutual Ins. Company, *Highlights: 2006-2007 Premium Rates*, April 5, 2006 at http://www.ismie.com/news/2006_0405_rates.pdf (last visited April 18, 2006).

195. *Id.*

196. *Id.*

of doctors and medical corporations that will instead experience significant premium increases. Thus, although claims paid have decreased by 14.3% since 2003 and net earnings more than doubled from 2004, ISMIE intends to raise rates on its insureds, even while giving some top executives pay raises of as much as 33%.¹⁹⁷

XI. CAPS ARE MISDIRECTED AND UNFAIR

As demonstrated above, caps on non-economic damages in medical malpractice cases do not protect physicians from the surging cost of insurance premiums. However, medical societies and insurance companies camouflage this truth, and instead point the finger at seriously injured victims of medical negligence and the juries who evaluate their losses. The medical societies and insurance companies demand legislative protection under false pretenses, seeking to subsidize their mismanagement on the backs of the most terribly injured, those who have already paid such an enormous price. Instead of corporate welfare at the expense of victims' welfare, government must pass legislation stringently regulating medical liability insurers.

Not only are they misdirected and ineffective, but caps on non-economic damages are terribly unjust. Caps penalize the few, depending on who injures them and how severely. The misfortune of the draw determines whether the tort system makes a victim whole. But, the status of the wrongdoer should not arbitrarily control whether the injured party is fully compensated. For instance, someone who is severely injured through the negligence of a truck driver is fully compensated for his pain and disability, but someone who is severely injured through the negligence of a physician is not. A patient severely injured by a defective medical device is fully compensated for his pain and disability, but a patient severely injured by the surgeon who negligently installs a safe medical device is not. Under the new statute, a patient severely injured by a negligent physician is compensated to a lesser extent for his pain and disability than a patient injured by a negligent hospital employee.¹⁹⁸

Caps on non-economic damages unfairly impact on the unlucky few severely injured by medical negligence, especially the young. An infant catastrophically injured at birth with a seventy year life expectancy has non-economic damages capped at \$500,000, the equivalent of only \$7,143

197. Bret Chase, *Caps or No, Ill. Adds to Doc Totals*, CRAIN'S CHI. BUS., Sept. 11, 2005, at 1. The cap legislation had no effect on ISMIE's 2005 earnings or losses because it did not effect pending cases. Pub. Act 94-677, 2005 Ill. Legis. Serv. 3440 (West).

198. Public Act 94-677 caps a plaintiff's non-economic damages at \$500,000 in suits against a physician, but \$1,000,000 in suits against a hospital. Pub. Act. 94-677, 2005 Ill. Legis. Serv. 3440, 3461 (West).

annualized over a lifetime.¹⁹⁹ On the other hand, a catastrophically injured 80 year old adult with a life expectancy of seven years receives the annual equivalent of \$71,430 in non-economic damages. The child must live far longer with his pain and disability, never knowing a life without devastating injury. Yet, the child is compensated for only one-tenth of his loss as compared to the adult. As the Wisconsin Supreme Court pointed out, “[y]oung people are most affected by . . . cap[s] on non-economic damages, not only because they suffer a disproportionate share of serious injuries from medical malpractice, but also because many can expect to be affected by their injuries over a 60- or 70-year life expectancy.”²⁰⁰

Caps absurdly discriminate between severities of medical injuries, providing less protection to those who suffer greater harm. A patient who is moderately injured and makes a complete recovery is fully compensated for non-economic damages, but the severely injured patient who never recovers is drastically under-compensated for non-economic damages. “Plaintiffs with the most severe injuries appear to be at the highest risk for inadequate compensation. Hence, the worse-off may suffer a kind of ‘double jeopardy’ under caps.”²⁰¹ The risk of loss is placed entirely on the backs of this small number of innocent victims left with profound disabilities and shattered lives. Meanwhile, the profitable insurance industry and well paid negligent professionals get undeserved and unneeded legislative protection.²⁰² As the Wisconsin Supreme Court keenly observed, “[n]o rational basis exists for forcing the most severely injured patients to provide monetary relief to health care providers and their insurers.”²⁰³

199. Illinois Civil Pattern Jury Instruction, Civil, 34.01 compels a jury to determine the amount of damages, including non-economic damages that will arise in the future and permits the jury to consider the plaintiff’s life expectancy when determining these damages. Non-economic damages are paid in a lump sum and the annual equivalents are for illustrative purposes only. *See* Illinois Pattern Jury Instructions: Civil, No. 34.01 (2005 ed.).

200. *Ferdon*, 701 N.W.2d at 466.

201. *Id.* citing David Studdert et al., *Are Damages Caps Regressive? A Study of Malpractice Jury Verdicts in California*, 23 HEALTH AFF. 54, 65 (2004).

202. According to the Medical Group Management Association, Physician Compensation and Production Survey, 2004 Report Based on 2003 Data, the national compensation of a neurosurgeon at the 50th percentile is \$644,683. Compensation is defined as reported W2 or 1099 income after the deduction of operating expenses, such as malpractice insurance, and does not include fringe benefits paid by the practice, e.g., retirement plan contributions, health insurance and automobiles. Medical Group Management Association, *Physician Compensation and Production Survey, 2004 Report Based on 2003 Data* (2004).

203. *Ferdon*, 701 N.W.2d at 466.

XII. CONCLUSION

The Supreme Court of Illinois has twice held that caps on damages are unconstitutional. In 1976, the Court decided *Wright v. Central Du Page Hospital Association*, holding that caps on damages in medical malpractice cases are unconstitutional. Twenty-one years later, the court in *Best v. Taylor Machine Works* held that caps on non-economic damages in bodily injury and death cases are unconstitutional.

Nothing has changed since *Wright* and *Best*, except another lap around the insurance industry's predictable economic cycle. Once again, medical malpractice insurance companies temporarily lost money on their investments, hiked up premiums, and then blamed it on the seriously injured medical malpractice victim. However, overwhelming evidence shows that the recent surge in malpractice premiums is not causally related to damage awards or indemnity payouts. Overwhelming evidence shows that caps on damages in medical malpractice cases do not reduce physicians' premiums.

So why were caps enacted yet again? Medical liability insurers cleverly manipulated their books to mislead physicians, lawmakers and the public into believing that Illinois is in the midst of another so-called "medical malpractice crisis" caused by non-economic damage awards. The deceived public is fearful of losing health care access, so lawmakers, wanting to be reelected, pass so-called "reforms", while doctors' premiums continue to skyrocket and medical malpractice insurers profit. This so-called "reform" is ultimately to the harm of those not backed by powerful special interests and who are unaware that they will someday need the protection of the courts, the seriously injured medical malpractice victim.